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THE AMERICAN JOURNAL OF PSYCHOANALYSIS

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FINDING THE REAL SELF

A Letter—with a Foreword by Karen Horney

FOREWORD: *The letter we have put at the head of this year's publication is a document of greatest value. It was written after only 38 hours of analysis by a woman patient of great integrity, a woman endowed with the faculty of concisely expressing what she feels.*

Five years prior to analysis Mrs. B. had suffered a severe nervous breakdown, occasioned by difficulties with her child. To bring it down to bare essentials, it was provoked by the patient's being confronted for the first time in her life with difficulties she could not overcome by reason and will power. Previously Mrs. B. had succeeded through consistent remoteness from herself and others.

It is not necessary here to go into details of either character structure or history. It is enough to say that the five years following the breakdown were years of intense suffering; years full of emotional upsets, of depressions, of states of unreality, of periods of self-hate and despair. With considerable understanding, a psychiatrist in a sanatorium helped her through the acute stages of her anguish. This letter was written to the psychiatrist and was motivated by a spontaneous wish to tell him about what she felt—and what has proved since then—to be a turning point in her life.

A year after she had left the institution, she decided to seek analytic help. She still gave the impression of great brittleness; she was subdued, tense, and full of palpable anxiety. The main area that unfolded in the first 30 analytical sessions was the relentless system of "shoulds" which dominated her. She experienced a turning against herself whenever she could not measure up to her rigid inner standards. Toward the end of this period, however, she took a positive step of great consequence. She started to wonder how much this kind of regimen stifled her spontaneity. From this the analyst drew courage to try to penetrate to her real self at this early stage with a question: "What do you really want?"

She was able to take up the challenge. She responded by realizing her loss of self and by visualizing the possibility of finding herself. All this is expressed in the letter. The insight was not a passing elation but indeed instigated a radical change in her entire outlook on herself and on life in general. She had found a piece of firm ground upon which to stand, from which she could safely tackle her neurotic problems.

Such an experience raises many questions most relevant for therapy. If the discovery of the real self is of incisive importance for therapy, how can the analyst help the patient to find himself? At what time and under which conditions can he try to direct the patient toward himself? Are there any dangers in approaching this subject prematurely? What, exactly, are the consequences of such a step? And, since the discovery of the self is usually not as dramatic as in this instance, how can we recognize and encourage the less perceptible moves the patient takes toward it?

I trust that we will be able to answer these questions in the near future—provided

our conviction about the importance of finding the real self proves well founded. The following letter will give us an incentive to investigate these questions.

Dear Dr. X:

You'll be happy to learn that you are the father and by now the grandfather of a small miracle—I nearly telegraphed you of it three weeks ago but thought I'd better wait and be quite sure. It is simply but definitely that I am getting well—at long last. Meaning of course "as well as the next guy," since our capacity for being human is almost never absolute. . . .

I mean just this: Until now I have known nothing, understood nothing, and perforce could love nothing, and for the simple, unbelievable reason that I wasn't here! For over forty years I have been exiled from myself without even suspecting it.

Merely to understand this, now, is tremendous. It is not only the end of all that dying, it is to begin life.

The story begins with your friendship, your generosity—when I was almost too sick to receive it. In the deepest sense that *was* my sickness. I couldn't be friends; I had never been free, humanly, nor ever wanted to be. And you did somehow get through in spite of me, although two years more were to pass before this final chapter. The end, now, the opening of the door, belongs to my present analyst, Dr. Y.

As you know, she didn't begin with me until September, and things have been moving fast, so fast that she too thinks it somewhat miraculous; but don't worry, she means to verify it before turning me loose. Now that I have both feet on the path, I don't care how rough the going may be.

It was a long journey brought me to her. Years of paralysis and depression. Then those months at the sanatorium. . . . Remember how you tenderly patched and bandaged me, and how on Easter Day you lent me the book *Our Inner Conflicts*? That day was the day I began to move. Of course I wasn't ripe for her sort of therapy yet, but I did react to that instant overwhelming recognition of myself, my neurotic self X-rayed upon the page. I did exist! Chapter Five and the end of Chapter Twelve were proof of it, illumination of it, and stirred me or the ghost of me from the limits of despair all the way to a new peak of exhilaration—on the strength of which I was able to come home, in installments. You know how difficult the next twelve months were: ceaseless effort to combat or to tolerate the days, nights, weeks, with my obsessive hallucination on the one hand and my own living "inhumanity" on the other; vain effort, punctuated only by occasional psychotic episodes. . . .

The last of these episodes, about Thanksgiving Day, was highly significant—although at the time I could see nothing in it but redoubled terror, guilt, and hopelessness. What was actually my first audible bid for life I then took to be just one more ghastly proof of madness, no more than a dim and desperate hallucination that "somewhere there must be a *meaning*, that somehow I would find mine."

By last spring a sort of cold peace had set in and I felt strong enough to begin thinking about psychoanalysis, and at last to get in touch with Dr. Y. She "would like to work with me . . . but . . . it was out of the question until next fall." I would wait. Then in May, while on a trip to Oregon, came my second overwhelming reaction to the written words—this time in *New Ways in Psychoanalysis*. I had scarcely finished the chapter on the "superego" when the very ground I stood on began to slip. Or, it was as though without warning or preparation, while I slept, my one remaining leg had been amputated at the hip. About all I could do then and during the next four months was to keep my eyes shut and try not to breathe until I could start work with Dr. Y in the fall.

Thus you might say I was "softened up" when I came to her, but I still had the disease; and she set to work ever so quietly but swiftly—*showing* me everything (myself in action), *telling* me nothing.

The first thing she tackled was that which was readiest at hand: my cast-iron "should system." My complete armor of "shoulds": duty, ideals, pride, guilt. This rigid and compulsive perfectionism was all that held me up; outside it and all around lay chaos. . . . She let me talk, fumble, stop, turn, begin

again, always going in circles until at last, little by little even *I* could begin to see what sort of strait jacket held me: I existed only because I *should!* I began to mention "spontaneity"—to dare think of it, and at last to realize how I longed for it— I who had always deliberately fought it, even in childhood! And Dr. Y. pointed out that there is an inverse ratio between genuine, spontaneous feelings and the "should system."

Then, on January 10th, she played a trump card—daring to play it so early in the game. Just four words! An apparently innocent, even naive question; but it was loaded. As she put it: "Perhaps there isn't even an answer to this as yet... but what *do* you want, really?"

I tried to keep it from striking home and retreated any way I could to defend what was still my sole *raison d'être,* but within hours the medicine began to work way down inside me. For the first time in my life I saw that I was quite simply unable to *want* anything, not even death! And certainly not "life." Until now I had thought my trouble was just that I was unable to *do* things: unable to give up my dream, unable to gather up my own things, unable to accept or control my irritability, unable to make myself more human, whether by sheer will power, patience, or grief.

Now, for the first time I saw it—I was literally unable to *feel* anything. (Yes, for all my famous super-sensitivity!) How well I knew pain—every pore of me clogged with inward rage, self-pity, self-contempt, and despair for the last six years and over and over again and again! Yet, I saw it now—all was negative, reactive, compulsive, *all imposed from without, inside* there was absolutely nothing of mine! There just was nothing. Had I been a little less numb I suppose I'd at last have cut my throat. And Dr. Y knew it.

This was it: the crisis, the turning point.

I went home and began once more to think down to the bottom of my rootlessness. Perhaps a week or two passed.

There is only one way out of chaos; and now that I knew all the other doors were locked, I made the tremendous discovery. The miracle that Dr. Y. had forced me to make on my own, not out of books this time —at least not directly—but out of my own bowels. From ten thousand miles away I saw it as a blinding light: the importance, the necessity of a Self! One's own single self. My original life—*what had happened to it?* Chaos was here—all around and in me—that I understood in all my fragments. But was that all one could ever know? What about the perfect planets, this earth, people, objects? Didn't they exist and move? Couldn't they be known? Yes . . . but there has to be a knower, a *subject,* as well! (Meaning is a bridge between *two* things.) Beginnings, direction, movement had to be *from* a single point; and ours is where we stand, alone, our being *sui generis.*

Suddenly vistas spread out and out to the sky, and all came together at my feet. Was it possible that I had touched the key to the universe—the key which every man carries so nonchalantly in his pocket? Instantly I knew in my bones, and by grief itself, that I had discovered the very core and essence of neurosis—my neurosis and perhaps every neurosis. The secret of wretchedness was SELFLESSNESS! Deep and hidden, the fact and the fear of not having a self. Not being a self. Not-being. And at the end—actual chaos.

With this (the hallucination to end them all?) I went to Dr. Y. and talked for two hours. My own calm surprised me. She listened intently. I knew this time she was not being just a spectator. I told her that at last I had seen my true poverty. I saw now all the way down, how and why, and how completely neurotic *needs* come to replace desires . . . until you are canceled out. One couldn't ask a starved man, a dead man, if he would *prefer* oysters to caviar; cut off from desires the very concept of *choice* cannot exist. Here at the end of this thought I had seen how neurosis happens and what it's all about. Selflessness! (The lack of self, of selfhood, of entity, of integrity.)

How is it possible to lose a self? The treachery, unknown and unthinkable, begins with our secret psychic death in childhood—if and when we are not loved and are cut off from our spontaneous wishes. (Think: What is left?) But wait—it is not just this simple murder of a psyche. That might be written off, the tiny victim might

even "outgrow" it—but it is a perfect double crime in which he himself also gradually and unwittingly takes part. He has not been accepted for himself, *as he is.*

Oh, they "love" him, but they want him or force him or expect him to be different! Therefore *he must be unacceptable.* He himself learns to believe it and at last even takes it for granted. He has truly given himself up. No matter now whether he obeys them, whether he clings, rebels or withdraws—his behavior, his performance is all that matters. His center of gravity is in "them," not in himself—yet if he so much as noticed it he'd think it natural enough. And the whole thing is entirely plausible; all invisible, automatic, and anonymous!

This is the perfect paradox. Everything looks normal; no crime was intended; there is no corpse, no guilt. All we can see is the sun rising and setting as usual. But what has happened? He has been rejected, not only by them, but by himself. (He is actually without a self.) What has he lost? Just the one true and vital part of himself: his own yes-feeling, which is his very capacity for growth, his root system. But alas, he is not dead. "Life" goes on, and so must he. From the moment he gives himself up, and to the extent that he does so, all unknowingly he sets about to create and maintain a pseudo-self. But this is an expediency—a "self" without wishes. This one shall be loved (or feared) where he is despised, strong where he is weak; it shall go through the motions (Oh, but they are caricatures!) not for fun or joy but for survival; not simply because it wants to move but because it has to obey. This necessity is not life—not his life—it is a defense mechanism against death. It is also the machine of death. From now on he will be torn apart by compulsive (unconscious) *needs* or ground by (unconscious) conflicts into paralysis, every motion and every instant canceling out his being, his integrity; and all the while he is disguised as a normal person and expected to behave like one!

In a word, I saw that we *become* neurotic seeking or defending a pseudo-self, a self-system; and we *are* neurotic to the extent that we are self-less.

Think what this 25th of January meant to me! From now on I had something to believe in, not yet in my *own* self perhaps—for to think it is not quite to be it—but at least I could believe in my *right* (innate, potential) to wish, to want, and to live for no purpose or reason other than that I do. *Sum ergo sum.* (Indeed, hadn't scientists "believed" in uranium long before they discovered it?)

I can see you smiling now as you read this because long ago you gave me the answer to this thing, though neither you nor I could correctly formulate the *question* that it answers. (Oh, the truth lies all about us like the grass.) You once told me, remember, that there were only two reasons for doing anything in life: either because it needed to be done, or because one wanted to do it. The clue is that word *want*—to wish, not to need. You know, as I do, that the neurotic, so far as he is neurotic, is no longer able simply to want or wish anything but is driven right, left, and around in circles by his compulsive needs, which can never be less than absolute starvation. He really does need everything, desperately, and therefore *cannot* give up anything; and there is no solution. He *has* no choice; alternatives he has (many, and all bad), but *who is there* to do the choosing?

And I remembered Dr. Z's neat description of the neurotic: The patient says, "I cannot"; his friends say, "He will not"; and the doctor says, "He cannot will." Now carry this one step further, and there is the reason which none suspects: He cannot will because he cannot even wish! Almost literally he is not there. He may strive desperately toward his goal and never make it (or at what a cost!), because *it isn't he* that is doing the striving. His real self is stifled by the neurosis, the Frankenstein monster originally designed for his protection. And it makes little difference whether you live in a totalitarian country or a private neurosis, either way you are apt to end up in a concentration camp where the whole point is to destroy the self as painfully as possible.

Having discovered the necessity for it, I now began to see the significance of the self. Oh, the million things you discover with the first touch of life! Almost before you've turned the key all the separate fragments

of existence rush to fall into place. How can you see, think, speak, remember fast enough to keep pace? Is there nothing which doesn't fit here, even dying and terror and broken things? There is nothing of it unknown to you, and little that the average healthy man doesn't simply take for granted —but I had never before seen the sun rise. How could I have understood that the self is as significant as humanity? And this is not at all Freud's ego, but rather, as William James describes it, "what welcomes and rejects." (Freud's ego and superego, as I understand them, *are* the neurosis!)

If our human purpose is to live and grow and express ourselves, then the *chance to grow* is everything—for it takes years, even with incalculable love or luck, to walk and wind our own willingness through the whole structure of things. Yet it is this willingness we can't afford to give up. It is our sole strength, our wish to live! Who gives it up, from fear or force, has to that extent lost himself; he is emasculated (well symbolized by Freud's "castration complex") and sold into slavery and compulsion. He may look like a man, but that is only his body, which he hopes will be fed. How shall he (being less than a man) bridge the gap between discipline and the self-discipline which is choice? How shall he take one step from utter frustration (from self-pity, scorn, greed, guilt or rage) to compassion, generosity and respect? Not by remorse, nor will power, nor broken-hearted charity; not by any miracle of "brotherly love" which is not and cannot be in his heart; not by suicide, murder, or the rope trick. Babe or neurotic, he cannot make one step forward because he *cannot want* to. And why in fact should *he* want to, he who sees only the cost and not the gain? (Unwilling renunciation is a kind of suicide and breeds more monsters.) You cannot will yourself to *want* a thing! I know. I've tried for years.

One thing only separates "I should," or "I need," from the simplest "I do want"—and that is not *choice* but the *freedom to choose.* (Sheer intellect and stupendous resolution are as nothing. The emotion is all: the "attaching of values," a man's entire meaning and content.) And this is the significance of the self: that it alone *can* choose. It has this freedom because it has and *is* the emotion. It is free because it has a place to stand—its own live roots, and not the shifting ground of expediency; and because it can have no ulterior motive. It relates directly to things. (I do not mean that such a self has no problems, no defeats, but that in choosing it will be limited by perception, and not by any effort of the will; its problems may even be insoluble but they will not be overwhelming.) At the very deepest level the self knows only two words—and it *wants* to say yes, that widest of words, because its only purpose is to be! In this sense I suppose dualism is not around us but in ourselves, our multiplicity of selves, which means always the distance from our true self.

Who for that matter would not rather *be himself,* affectionate and free, if he could afford it? No other self is free to feel, to express our nature, to know another and be known. This alone is the human self, that can go out; that can love, and endure, and be loved—because it wants to live.

NEUROTIC GUILT AND HEALTHY MORAL JUDGMENT

MURIEL IVIMEY*

THAT SEVERE and intractable guilt feelings can operate as a serious block to progress in analytic therapy is well known by experienced psychoanalysts. One would assume that a sense of wrong doing would open the way to reorientation of values, constructive efforts, and realistic strivings toward healthier ways of life, but experience shows that we must reckon with a sense of wrong doing which is not only totally unproductive, but which tends to drive the patient toward chronic and unremitting self-torture, despair, and sometimes self-destruction. If this kind of guilt has been accurately understood and if the problems associated with it have been well analyzed and worked through, we find that the patient comes to experience a sense of wrong doing which has a totally different quality. There is no plunge into a hell of gloom and self-recrimination, but a sense of relief, of cleanness, a sustained facing of the issues, and the beginning of real hope and interest in remedying matters. We must conclude that we have to deal with two kinds of guilt feelings—one unproductive, obstructive, and potentially or actually destructive; and the other potentially productive and constructive. The title of this paper indicates this differentiation—neurotic guilt and healthy moral judgment.

A careful and serious study of Horney's theory of neurosis helps to clarify the serious technical difficulties encountered in dealing with problems of neurotic guilt and also points to the value of observing and utilizing the patient's true and constructive moral judgment. According to Horney's theory, neurotic or destructive guilt feelings are the outcome of neurotic developments. Neurosis inevitably entails impairment of moral integrity. This is expressed in a variety of ways. In some individuals, there is an intense conscious concern with moral problems, with right and wrong. But when we study the individual's moral values in detail, we encounter many glaring distortions and paradoxes. What is really bad has become good, and what is really good in human affairs has become depreciated and rejected. In other individuals, we see that the concern with what is good or bad has become such a confusing, torturing, and fruitless preoccupation that attempts are made to throw it out of consideration altogether, as a means to attain some peace of mind—only to have it recur with renewed intensity under the stress of inner tensions and external vicissitudes of living. In still other individuals, moral considerations have been successfully dismissed from consciousness, and the individual tries to get along in com-

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Read before the Association for the Advancement of Psychoanalysis at the New York Academy of Medicine, Jan. 26, 1949.

*M. D. Johns Hopkins, 1922; Associate Dean, American Institute for Psychoanalysis; lecturer; practicing psychoanalyst.

plete cynicism—leading to greater disturbances in the inner life and in relationships with others. The neurotic has, to a greater or lesser extent, become unable to distinguish or estimate what is realistically right or wrong, good or bad, in his attitudes, his thinking, and feeling about himself and about others.

By right or good, we mean what is good for a human being's personal growth, his development, and the fulfillment of his destiny as a whole, productive and creative human being—untrammeled by neurotic inhibitions, uninfluenced by compulsive needs and undistorted by illusions about himself and others. When moral values are in harmony with what is good and right for human development, a person has a genuine appreciation of himself and others; he is guided by an honest and realistic appraisal of himself and others, and he is free to experience his own real, spontaneous feelings, to make the most of his real capacities and to explore and experiment with his potentialities. This would conduce to a full sense of living, to freedom in his relations with others, to spontaneous and active sharing with others, spontaneous and active contributions to the welfare and happiness of himself and others. Where there are irreconcilable issues between his own wishes and interests and those of others, he would be able to make a stand and come to a clear decision one way or the other and to take the responsibility for good or ill. As he grows in mental and moral stature, he could change his stand and his course of action, according to a better understanding of what is good for himself and others.

None of us knows finally what is good; we are prone to more or less imperfect moral concepts, but we can strive to clarify and then to reclarify them for ourselves and aim ultimately to cultivate them in their highest and best form. Our work as analysts entails helping others to solve their life problems. We do not determine for others what is good, but we seek to help our patients to free themselves from confusion and distortions so that they may determine what is good for themselves and direct their lives along the lines of their own spontaneous choice. It is inevitable that the analyst will indicate his own position through the very raising of questions, through indicating that there are moral issues at stake of which the patient has been unaware, through implications and sometimes through direct expression of his own personal opinion. But this is done in the spirit of stimulating free discussion and consideration of differences, where they exist. It offers the opportunity for each one, patient and analyst, to reflect, to reconsider, and to change if either one sees fit spontaneously to do so. Regarding what is good, I should like it understood that I am referring to basic, fundamental human values and not to conventional standards as set forth by special social, religious, or political ideologies. These standards may correspond to what is fundamentally good, or they may not.

As to a theoretical understanding of disturbances in moral integrity in neurosis, we would start with certain considerations upon which Horney has focused in a recent series of lectures.[1] These lectures will be included in a forthcoming publication. In them Horney has been concentrating on the split in the personality which results from the individual's attempt to create an illusion of wholeness when his personality is actually torn by inner conflicts which would otherwise exhaust and overwhelm him. The person tries to escape from his conflicts by letting his imagination construct a conception of himself in which there is or ought to be nothing at all the matter. In this conception all his contradictory traits, all his inconsistent thoughts and feelings, his whole neurotic way of life—all are entirely admirable and virtuous. He feels there is nothing really inconsistent or out of order about him. Since in imagination the sky is the limit, he goes further: The natural qualities and capacities he possesses become enhanced and transmuted into unique, superlative gifts; and still further, he can endow himself with capacities he simply does not have at all. This is the construction of the idealized image. But an illusion—no matter how necessary, or comforting, or relieving, or fascinating—is still an illusion. It does not

[1] "The Search for Inner Unity." Delivered at The New School for Social Research, Spring, 1949.

erase reality. The fact remains that all is not well. The person is still bound to his compulsiveness and beset by fears, still suffers from inhibitions, weaknesses, and frustrations. He really has just average intelligence, or only superior intelligence; if he has special gifts they are probably undeveloped, and it would remain to be seen whether or not they are of genius caliber.

With idealization of the personality, the self as it really is becomes by comparison something to be ashamed of—unattractive, unworthy, a part of the personality which is always threatening to emerge and disgrace the person. It is his skeleton in the closet, or, as Horney has said, a disreputable poor relation who discredits and belies the image. We believe that this idealization of the personality is the direct cause-and-effect explanation of the individual's rejection of his real problems, his real abilities and limitations—and if his abysmal shame and guilt about them.

This development leads to a reversal of real human values. His inner life in a mess, the individual is so ashamed and disgusted he turns his back on himself and loses interest or faith in any capacity he might have to help himself. This is bad for him, but he feels it right and proper to desert and despise himself. His factual abilities fall so far short of what he can dream up about himself that he gives up the attempt to exercise and cultivate what he has. This is also bad for him, but he feels it good to be outraged at qualities and performance which fall short of a fantastic standard of perfection. This makes him, in his own eyes—and he thinks in the eyes of others—a superior person who detests "mediocrity," who knows what's what. But all the while he is not even trying to do what he can with what he has and from that point improve and become better. He hates others who are active and productive, and he feels good if he can spot their limitations and shortcomings. This is again bad for him because it frightens him away from making any efforts of his own. Or he regards other active and productive people as specially endowed, favored by the gods, on a different plane. They have been allowed to "graduate"; they sit among the elite; what they produce flows out of them with no effort on their part. This is bad for him, for he has lost a sense of common ground with others. His thoughts eliminate the factor of effort which active people make to do or achieve something and which he also would have to make in order to be productive.

On innumerable finer points, the false and the spurious are given positive value. Being helpless, being inert, having nothing to do with others, pushing others around, bullying, overriding, being vindictive, paying others back, hating someone till one's dying day—these qualities can be elevated to the highest virtue, to a point of honor. And there are innumerable qualities related to what is really good which the neurotic repudiates as unimportant, unnecessary, not worth-while. The idealized image has seduced the conscience into accepting and approving that which degrades and stultifies, and into rejecting and despising attributes and capacities which would promote and stimulate growth and well-being. A person cannot get rid of neurotic guilt so long as the conscience is thus perverted. This perversion of moral values constitutes one of the crucial problems in therapy. This theoretical understanding enables us to clarify moral issues and to help our patients to achieve substantial gains in working out their problems.

Freud's View of Guilt

I think it will help to clarify what I have just said if I describe briefly where psychoanalysis stood on the topic of guilt feelings prior to our recent advances. Freud saw his patients bogging down in irrational guilt feelings; he saw them sticking in a state of utter inability to break through, to dissipate guilt feelings and make progress in treatment. He saw that these persistent and chronic, tormenting self-accusations (on the score of sexual matters) were reactions to failure to conform to an impossibly strict and harsh moral code. He saw this code emanating from a hypothetical structure which he called the superego, and hypothesized further that this superego was addressing itself with blame and censure to the weak, impotent ego, or self, or I. He considered that the function of the superego was to regulate the drives of the primi-

tive, completely amoral, instinct-driven id, or unconscious, in man. Thus the ego was caught between the superego and the id. Freud regarded severe, irrational guilt feelings and self-punishing tendencies as expressions of a force inimical to well-being, since the ego was unable to escape from or combat them, as evidenced by the bogging down in self-condemnation. He identified this force with a death instinct inherent in all animate matter, including man, which drives a person to destruction under pressures of guilt, or at least blocks the road to recovery and well-being. The forces of the id he identified with the life instinct, or pleasure principle, or Eros, which bids man to pursue happiness and fulfillment with no moral or ethical considerations.

How did Freud envisage a possible solution or salvation for the weak ego, caught between these two forces? He credited the ego with capacities to think and reason, but not with a capacity to grapple with moral problems, release itself from irrational self-accusations, or to establish sound moral principles and be guided autonomously by them. The patient must resolve irrational guilt feelings by rational repudiation of the dictates of the superego. He should be able to do this if he has understood and accepted analytic interpretations. But if he was successful in throwing off the yoke of the superego and freeing himself from irrational guilt, it was obviously impossible to permit the forces of the amoral id to have full sway in civilized society. Again, rationally, the patient must bring himself to accept the rational morality of society. This left the patient still subject to *instinctive* forces driving him in the opposite direction, and he would have to rely, theoretically, on the presumably less powerful dictates of reason. This problem—how the forces of life and death ultimately become dissolved or coalesced—was unanswered, as Freud states in the paper "Analysis Terminable and Interminable."[2]

Freud's attitude toward the part that guilt played in preventing recovery led to the conclusion that an inner sense of guilt was abnormal and undesirable. And this would seem to lead to the conclusion that Freudian analysis rejects morality. These factors have caused psychoanalysis to be viewed with alarm and indignation by many people. But Freud was a sincere and ardent moralist. He considered it essential that the patient give up the strangulating morality that precipitated a degree of guilt, that forced him into black despair and paralyzed his interest in life and efforts to get well. This is a point that many non-scientific students of psychoanalysis have not grasped. Freud considered it essential that the patient come to terms with unbridled exercise of primitive instinct, and he considered it essential that he reconcile himself unequivocally with commonly accepted and necessary decencies in human society. This is a second point which some of his critics either overlook or of which they are not aware. Freudian psychoanalysis does and does not reject morality. It rejects the scientific study of problems relating to morality in neurosis, *and* it wants to help the patient solve them. The dilemma is solved by directing the patient toward external solutions.

The Religious View of Guilt

Since some religious leaders have crusaded against psychoanalysis as being, in their opinion, an evil influence, I want to make a few comments on the two points of view regarding the role and value of guilt. Orthodox religion holds that it is an essential force in impelling the sinner to seek salvation and thus gain everlasting life. Freud, the scientist, sought to understand certain forms of human suffering and their alleviation and cure. Irrational guilt feelings were seen to obstruct recovery, a block to attaining peace of mind and freedom from conflicts and their devastating consequences. But civilized man must attempt to conform to the moral values of society. The doctrine of original sin in orthodox religion and the doctrine, according to orthodox psychoanalysis, that man is fundamentally amoral, at bottom a creature of instincts—these two doctrines bear a close resemblance to one another. One, derived from Scripture, adheres to the account of the fall of Adam; the other is derived from a mechanistic

[2] International Journal of Psychoanalysis, Vol. XVIII, 1937.

evolutionary theory which holds that there are only quantitative differentiations in the development of higher forms of animal life from lower forms of life. According to this view, no qualitatively different and new factors appear in higher forms of life, such as, in man, a conscience or a capacity for moral judgment. From an orthodox religious point of view, salvation from a state of sin and from punishment in the hereafter is achieved through a sense of guilt, the acknowledgment of sin, the mystical experience of grace, forgiveness conferred by a minister of the church, and the acceptance of the moral teachings of the Savior. Man is credited with a capacity to appreciate and respond to morality emanating from a supernatural source, but not with a capacity to guide himself morally. From the orthodox psychoanalytic point of view, liberation from psychic suffering is achieved through insights and working through the problems thus revealed. Man rights himself through awareness and acknowledgment of his instinctual drives and the acceptance of good and decent social patterns. He has the capacity to appreciate and accept the guidance of civilized moral values but not to formulate a moral philosophy for himself and live by it in a responsible way.

A Broader View of Guilt

We have seen irrational guilt feelings in much the same light that Freud did. They are one of the blocks in the road to recovery, and they must be dispelled. We have seen that they are expressions of a sense of failure to live up to impossibly high and strict standards of conduct and performance. But irrational guilt feelings have been studied in a much broader and deeper way and in much greater detail. The consideration of guilt feelings is not limited to those concerning sexuality, but it has been extended to include a sense of wrong-thinking, wrong-feeling, wrongdoing in all other aspects of a person's life. As to detail, we pay attention to the many ways in which guilt is felt and expressed—tendencies to scold oneself excessively, to accuse, berate, belittle and condemn oneself on account of real shortcomings and also on account of traits and behavior that are not in any way reprehensible. Related to guilt also are many vulnerabilities, fears of being found out, expectation of the condemnation of others, penalties and punishments which the individual inflicts on himself and on others. We also include manifestations of attempts to escape from self-accusations and self-contempt, wherein a person turns to condemnation and blame of others, suspicions of evil in others, seeking to make others feel ashamed and guilty.

The superstructure, or idealized image, whence come irrational self-accusations and guilt feelings, has been studied in more detail. This superstructure corresponds to Freud's superego but is radically different in concept. We would see it as a neurotic development, not as a universal instinctual manifestation; we would see it affecting all phases of the individual's life, not merely the regulator of instincts so powerful as to be uncontrollable by moral considerations. The idealized image is the creation of the individual's own imagination, called into being by the dire necessity to quell the chaos of his inner neurotic conflicts, so that he may function with some sort of equilibrium. The idealized image for each individual varies from that evolved in other individuals according to the particular neurotic character structure. We would not envisage a universal "superego" which approves and disapproves the same thoughts, feelings and behavior. According to our concepts, what one person would hold valuable and would feel ashamed and guilty about would be unique for him, and such things could be quite different from what another person would obsessively strive for as an ideal and obsessively despise himself for failing to recognize.

We have considered the irrational nature of neurotic guilt feelings, and we have seen that they represent one of the impairments of moral integrity resulting from neurotic developments. We might say that the factor in human nature subserving moral judgment—that is, conscience—is thrown out of gear, over-activated, supercharged, inflamed by the nagging complaints of the idealized image, or overwhelmed and paralyzed because of sheer inability to satisfy the impossible demands of the idealized image. Conscience cannot function according to true values; a person is at the mercy of a con-

science which misdirects him. It approves and sets up as good much that is actually bad and it fails to register what is wrong with the real self and to point out a right course.

Freud's concept of ego was never very clear, probably because he ignored qualitatively new factors in human nature, especially the new and highly sensitive and highly discriminating factor of conscience as part of human personality. Our concept of self, corresponding to the nebulous Freudian ego, is that it is the vital core of personality containing potentialities for personal growth, development, and fulfillment. In neurosis these constructive forces, including moral judgment, have been to a large extent diverted into the service of safety requirements—first against an actually adverse environment in childhood; then into overcharged, anxiety-driven compulsiveness; then into defenses against inwardly generated anxieties caused by inner conflicts; then into false solutions of conflicts. With the construction of the idealized image, one of the false solutions, the individual turns against his real self and irrational, neurotic guilt comes into play. What is "good" for the patient is strictly determined by his inner necessities for safety and equilibrium. He becomes, of necessity, totally one-sided and must keep himself blind to connections between his distorted values and the many serious disadvantages and the suffering that are thus incurred. The greatest of his sufferings is neurotic guilt resulting from his turning against himself.

Therapy and Guilt

We would tackle problems of neurotic self-accusations and irrational guilt feelings as follows: Since the individual has made up his own idealized image (which bids him despise himself) he can unmake it, provided he comes to a genuine appreciation of the extent to which he has abandoned himself to his imagination and of the mischief thus created. Irrational guilt feelings are not the expression of a self-destructive, or death, instinct, but the reaction of the real self which is tyrannized and beaten down by the individual's imagination of what he ought to be. When the patient dispels his illusions about himself, irrational self-accusations and self-frustrations cease. This can be a long and arduous process, but it gradually opens the way to a reorganization of values and considerations of what the patient spontaneously wants to do about his life.

The first job at hand is the question of the person's own treatment of himself as a human being. His attention is called to self-deception, stultifying pretenses, how he has made up a story about himself out of whole cloth, how he has entered into a self-perpetrated plot to cheat and abuse himself. The reduction of the idealized image and of irrational charges against oneself is accomplished not entirely by rational processes, not entirely as a result of logical explanations, not as a result of reassurances from the analyst that he really is a worth-while person, but as much and more by calling upon the patient's moral judgment, however weakened and warped it may be. We would see to it that such questions as the following emerge in the course of the work of analysis: Is this right, fair, just, honest that a person so deceive himself, that he so shame and stigmatize himself? And for what? For weakness, for being in trouble, for being afraid, for being confused, for having lost his way, for having only the good resources he does have and not the supreme intellectual powers or the goodness of a saint—even for having resorted to foul play against himself and others in his desperate attempts to keep going on any basis? What is he doing to himself with this great overblown, fantastic notion of himself and with this brutally self-recriminatory attitude toward himself which crushes all his confidence and self-esteem?

The products of a conscience inflamed by the idealized image are irrational guilt feelings. The products of conscience relieved of the overload of impossible demands are normal, productive guilt feelings concerning personal shortcomings and weaknesses that actually ought to be set right and can be set right. With productive moral judgment there comes a sense of hope and anticipated achievement if one is genuinely and wholeheartedly in process of working at one's problems, and a sense of peace and well-being with each success. A clear distinction is to be made between neurotic and healthy guilt feelings. Neurotic guilt obstructs prog-

ress; healthy guilt provides effective leverage to go forward and make changes. Neurotic guilt causes constant and endless pain if it is experienced directly. If it is not experienced, the neurotic individual has avoided it by resort to some anesthetizing device, which brings suffering anyway. Healthy guilt feelings are associated with pain, but of a quality which is immeasurably less poignant because of the sense of wanting and being able to change.

This distinction is essential in the dynamics of therapy. If the therapist does not make the distinction and thinks only of guilt feelings in general, he is bound to make one of two mistakes:

1. Coming upon irrational guilt feelings, he might recognize them correctly as obstructive and problematic, arising from too great demands the patient makes upon himself. But he might stick to this attitude toward any guilt feelings and fail to recognize constructive moral judgment which would serve as a stimulus and directive for the patient in working at some problem. He might unwisely minimize or soft-pedal healthy guilt at a time when constructive moral judgment needs confirmation and encouragement.

2. If the therapist's attitude is that guilt feelings in general should stimulate the patient to work, he may be hasty and superficial toward tormenting neurotic guilt feelings and overlook problems related to the idealized image which need to be worked at. This attitude could wreak unnecessary hardship and suffering for the patient who is still under the tyranny of an idealized image and not yet on sufficiently good terms with his real self to be interested in himself.

A Case of Guilt

Patients vary in respect to manifestations of irrational guilt feelings and in respect to the availability of constructive moral judgment. In some individuals, irrational guilt feelings are right on the surface; they may be a presenting complaint and dominate the picture at the beginning of analysis. Others show no moral judgment of any kind, but it emerges in the course of analysis as the personality unfolds. In still others, the sick conscience grumbles and complains chronically behind the scenes, as it were, not coming to the fore with direct self-accusations. In still others, the individual has fits of black guilt which run a course and disappear as if by magic—like an attack of gallstone colic. In the case of a woman patient currently in analysis, the conflict between neurotic pride (idealized image) and self-hatred (the despised image) was raging out in the open and fully experienced by the patient. Her main solution was a partial withdrawal from this inner battle and a concentration of the conflict on the lives of her two sons. Her attention hovered between the two boys and herself. Toward them her attitudes and behavior shifted capriciously from fantastic adulation to pestering concern for their achievements to vicious derogations of them. She was fulsomely adoring, over-indulgent, and deferential to them and just as callously neglectful and frustrating. Toward herself she was similarly grandiose and self-debasing. The home life was bedlam, and inwardly the patient was in torment because in addition to her own self-hatred, she had to endure the contempt of the two inflated and somewhat sadistic youngsters.

It was decided early in analysis to focus on the intrapsychic aspect of the conflict, to postpone detailed discussion of relations with others, and to tackle her tormenting self-recriminations. Some very general comments were made relating to some patently fantastic ideas she expressed regarding her physical appearance, her qualities as a mother, and her intelligence. The main emphasis at first was placed on the topic of appearance. Her attention was drawn to her overwhelming disgust and rejection of the objective facts in this respect. A direct appeal was made to her judgment as to her treatment of herself. She responded with the question: "How do you know I have any judgment? I'm a fool and a wicked mother!" Bearing in mind the distinction between neurotic guilt and healthy moral judgment, it was pointed out that she had shown plenty of evidence of having judgment; but it was too intense and merciless, and she crushed herself so thoroughly that she was unable to make the most of what she had. She was using judgment as a weapon against herself instead of a tool to

help herself. She saw this quite clearly, and within six weeks she adopted superficially a better attitude toward herself and initiated some quite constructive changes in behavior and activity. These included changes in the way she felt about her clothing, in her attitudes toward her husband and the boys, and in her feeling about her mentality. These changes were sustained for only a few weeks, but she had had the experience for a short time of a very different kind of life. This is valuable because it provided a contrast; it gave her some ground to stand on; it showed her possibilities and it provided important material for discussion in subsequent analysis of insufficiently worked-through problems. Two knotty points, among other problems, were the subjective values and the neurotic gains she derived from both her fantasies of exaggerated worth and of weakness and resourcelessness. Discussion of values is an important part of the work. As time goes on, the patient becomes increasingly confident in her own discernment, for she has come to engage spontaneously in debates with herself. Sometimes she comes to sound conclusions and takes a forward step. Sometimes an inner debate leads to her getting fed up when the issues are too evenly balanced; she then gives up and veers off again into self-recriminations and abuse of those around her. One has to be alert to the patient's tolerance and to stand ready either to help or to ease off. On the whole, however, it is possible to observe an ebb and flow of irrational guilt and healthy moral judgment and to see a gradual shift from the destructive to the constructive.

Moral Values

Where guilt is not experienced consciously, where it is invisible, where it is cloaked in symptoms or appears only in occasional outbursts, I believe the problem is best approached through a consideration of the patient's moral values. In the earlier years of our psychoanalytic practice we are constantly startled by the chaotic state of the patient's values and dismayed by the apparent absence of any values at all. If one focuses on this scrambled morality, one will find in every analytic hour many expressions of distorted values. Whether or not we take them up for discussion immediately is subject to considerations concerning selection and timing of interpretations—but it is essential that distorted values be noted and discussed at some time. Tentative comments are sometimes quite fruitful and often lead to fuller and more specific revelations in this area. If the time is ripe for questioning the patient's values—and I am all for free experimentation but not reckless attacks—the sooner the patient becomes aware of the disorder in this area, the better, and the sooner constructive moral judgment is awakened.

The distinction between neurotic self-recrimination and irrational guilt on the one hand and positive, morally critical attitudes on the other is readily made if one observes the patient's reaction to some discussion of moral issues. In the first case, irrational guilt feelings would be accompanied by depression, fatigue, hopelessness, inertia—the characteristic bogging down; or by anxiety concerning coming to the next analytic hour; or resentment against the analyst, accusations that the analyst is trying to make the patient feel bad or a complaint that the analyst is not supposed to inject anything relating to moral judgment into the analysis. Such reactions are signals pointing to attempts to ward off the pain associated with neurotic guilt. Very strong and persistent resistance to the topic of moral values is a warning to proceed cautiously or to postpone until the patient is stronger. For irrational guilt is related to self-hatred and has a self-destructive component.

On the other hand, constructive moral judgment on the part of the patient, expressed in a realistic appraisal of some characteristic, is experienced with some pain—but there is, along with pain, a feeling of interest, wanting to stay with an issue, to re-examine it as if in anticipation of something hopeful and profitable to be done about it. One feels a sort of inner concentration in the patient, and his productions are more in the nature of his wanting to reflect on his own, rather than appealing to the analyst's judgment or arguing a point with him. If the analyst recognizes this in the patient, it is important to leave the patient to his own reflections unless invited to par-

ticipate. Remember, too, it is an invitation to participate and not to take over. Many points will come up between analyst and patient on which there is plenty of room for genuine and honest differences of opinion. In case of such differences, the issue for each will be based on what is essentially right and wrong, and each will feel he can genuinely respect the position of the other. Many other issues will be cloudy to the patient, and he may wish or need some help in direction—direction in the sense of orientation, but not management or dictation. Under these circumstances it is the analyst's responsibility to offer personal opinion if it is timely according to the patient's readiness to appreciate it as a personal opinion.

Conclusion

The recognition and utilization of constructive moral judgment are two of the most important contributions to our present practice in therapeutic analysis. Freud seems only to have considered non-productive, irrational guilt feelings and not to have recognized the constructive potentialities of spontaneous, healthy moral judgment in human nature. His concept of constructive forces in the therapeutic process was limited to the patient's rational faculties and what was called positive transference in his relations with the analyst. We would say that irrational guilt feelings are the products of an overburdened conscience, that conscience is a natural and essential part of human nature. When relieved of the excessive demands of the idealized image, this "organ" of moral judgment operates as a sensitive gauge to indicate inwardly for each individual what is really good and what is really bad, what is right and what is wrong.

REASSURANCE IN THERAPY

ALEXANDER R. MARTIN*

TO REASSURE means "to free from fear, anxiety, and terror." This definition has a special relevance for modern psychiatry because in recent years anxiety has become a most important focus of psychotherapy. Before we can reassure intelligently, we should have some idea of what constitutes anxiety. Its most characteristic quality, to which I wish to give particular attention, is its unamenability to reassurance—that is, reassurance as one *ordinarily* understands it.

Subjectively, anxiety is a state of apprehension, a fear that something indefinite and terrible is imminent, and no amount of ordinary reassurance can in any way convince the anxious individual to the contrary. Subjectively comparable to anxiety but dynamically different are those emotional states of fear, terror, and phobia related to something definite and specific. The individual may feel these states to be rational or may accept them as irrational; but here again the common quality is their unamenability to reassurance. Where there is apprehension, feelings of impending disaster and similar expressions of anxiety, we say the fear has not been objectified or externalized. In the phobias, we say there has been objectification or externalization of the fear. There is good reason to think that the process of objectification which occurs unconsciously is always preceded by a brief or prolonged phase of anxiety, is a protection against that anxiety, and is an attempt therefore at what we could call internal reassurance. That is, the individual, through natural, unconscious processes within him, attempts to relieve his own anxiety. The phobia, or objectified fear, is more tolerable than the non-objectified anxiety.

One doctor, when referring a panicky apprehensive patient, told me that in response to his age-worn reassuring cliché, "My dear, there is really nothing to be afraid of," the patient quickly said, "Oh doctor, that's what's the matter—if I only had something to be afraid of."

We should in therapy consider the internal forces as well as the external forces that help to reassure. In the case of phobias, any external forces which initiate or support this unconscious process of objectification are assisting the individual to relieve his own anxiety. It may be necessary for a time seemingly to be on the side of this protective, anxiety-relieving, reassuring function of the neurotic pattern, to go along with the objectified fear and not minimize it or make attempts to dissipate it without realizing that we may thereby be bringing about panic,

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anxiety, apprehension that is much more intolerable to our patient. Insight into the superficially reassuring value of any neurotic defense and its abandonment is never accomplished by immediate and direct focusing upon it but will only proceed as its role and value in the patient's whole context of living is brought to his realization.

We must have respect for symptoms and appreciate that they represent nature's attempts to overcome a problem so that growth can proceed. This does not mean that we sit passively by and leave nature alone, but, rather, that we try to find out what nature is doing, why she is doing it, and get on her side. Take the simple example of thumb-sucking. Certain children suck their thumbs when they are tired or hungry, when they are left alone, when they lose favorite toys, when new siblings arrive. We can speak of the young child who sucks its thumb as being disturbed and can see that thumb-sucking is soothing, quieting, and relaxing. We would do well not to interfere with this but rather see it as a protection against and an indication of some deep dissatisfaction and disturbance in the young child. Thumb-sucking is a kind of reassurance on a tangible concrete perceptual basis, which is the *only* basis whereby a child can be reassured. To interfere with it, without searching for and doing something about the basic disturbance, produces what we could now call anxiety and/or more complicated and inaccessible defenses against it.

As it is with thumb-sucking, we find that many of nature's earliest and therefore simplest ways of giving reassurance are not socially approved. Lonely, deserted, unloved, frightened children are spanked for masturbating, or rejected, isolated and stigmatized as "homosexual" in cases where their loneliness and need for affection impels them to get into bed with one another. Here society rejects nature's "attempt at cure" and does nothing about the original source of dissatisfaction, and so new and more devious ways of relief and reassurance will be sought. Under stress, conflicting ways are sought and it is the existence of these acquired conflicts which, though out of awareness, is one prerequisite in determining anxiety.

Consider the frequency with which the physician and psychiatrist promise removal of symptoms as a reassuring approach. That the symptom happens to be the patient's principal defense against anxiety is not appreciated. The threat of its being taken away arouses unconscious resistance to its removal and the reassuring physician is greeted with the characteristic repudiation, "No, I don't think I'll ever get rid of it. I've had it a long time, doctor, and I don't think there's anyone could ever cure me." If we continue to blast away at some neurotic symptom before careful and patient analysis and reorientation as to function have been undertaken, we may be greeted at the next session by a completely changed patient, outwardly more comfortable and optimistic. We may be told, "Doctor, I am greatly reassured by what you told me." Here, the real cause of what looks like improvement but which is nothing more than shallow, starry-eyed euphoria has been an unconscious shift over to another neurotic defense, with compliant sycophantic elements. The patient felt your strong rejection of his earlier and therefore simpler neurotic defense and now wants your approval. Hence, as a result of what was intended to be reassurance, we are now confronted with something which will be more complicated and more inaccessible to basic reassurance.

What has been said is especially applicable to the great problem of sleeplessness, that meeting ground of the physician and the psychiatrist. It is imperative, especially in its incipiency, that sleeplessness be approached from the dynamic point of view with due regard for its possible value to the patient and its function in the patient's whole context of living. It is a condition that constantly invites reassurance, although psychoanalysis has shown how disturbing it is for many patients with sleeplessness to be told by the genial, reassuring doctor, as he leaves, "Don't worry, we'll see to it that you get a good night's sleep." Such patients who insist they are going to stay awake have a great fear of sleeping, a great fear of being unconscious; there is usually a great fear of anesthesia. For them it is imperative to be alert, to be in full command of their senses. While they stay awake, they can maintain their way of living, which is the neurotic de-

fense against the emergence of conflicts which, for some reason or other, has become imminent.

From what has been said, it is possible to consider reassurance under three main categories: (1) false reassurance, (2) superficial or defense reassurance, (3) basic reassurance.

False Reassurance

In general, false reassurance occurs where there is a complete disregard of the unconscious determinants of behavior and a failure to see the value and function of symptoms. Opportunities are missed to give patients a broader perspective and a more meaningful orientation toward their symptoms and their whole way of life. Deep within themselves, the patients feel that you cannot really help them, and because such reassurances are so readily forthcoming from those in the highest places, they are completely justified in feeling that no one understands them and can help them.

The questions, "You know I'm not going to get well, don't you?" or "Do you think I'll get well, doctor?" or the comment, "I don't think I'll ever be better," are all traps for the unwary. They are statements that give the real therapist an opportunity to show the patient that there is no simple answer, that the patient is certainly asking for something, but verbal assurance is not it, because he's already had it. (I have told certain patients they might have their symptoms for many months, and this resulted in a lessening of their anxiety. Here, I was partially freeing them from anxiety, and yet I was not, in the ordinary sense, reassuring them.)

One of the commonest examples of false reassurance occurs with certain patients having objectified somatic fear—let's say a fear of tuberculosis. The well-intentioned physician takes X-rays and produces objective proof the patient is in excellent physical health. Instead of being relieved, this is followed by a return of the non-objectified anxiety, even to the point of panic. Or the patient may go into a manic or depressive phase.

False reassurance is all too frequently dispensed to patients who express strong feelings of self-depreciation, self-disparagement, self-hatred, belittling, etc. These are symptoms which invite an encouraging, reassuring approach from the physician. In these instances, the doctor's verbal reassurance—expressions of confidence, faith, encouragement—are practically automatic, because the patient's self-disparagement, self-depreciation, belittling are so completely unjustified objectively. This "cheer-up," slap-on-the-back approach to the depressed patient is still widely practiced, either explicitly or implicitly. The patient continues to defend his poor opinion of himself even more strongly.

There is a school of thought which holds that patients are reassured if you "treat them as if they can take it"—accordingly, a patient with severe stage fright is forced to go on the stage, a patient with a stammer forced to get up and speak. Help is withheld on the basis that if you give help, the patient will become dependent on you. This latter attitude is to some extent derived from the Freudian philosophy of destructive instincts according to which we control and discipline the growing individual out of fear, rather than out of respect. There is also the implication that if we do things for the child, the child will never want to do things for himself. In those instances where force is successful and the patient "regains the strength to overcome his fear," the symptom is replaced by a less obvious and a more devious and complex defense against anxiety and more serious inner conflict.

One young patient was very afraid that he would lose the watch his father gave him. The fear obsessed him—he talked to his family doctor about this "crazy notion." He wanted to leave the watch at home. The family doctor told him that the only way to overcome the fear was to take the watch with him wherever he went. Within a week the boy had lost the watch.

What is mistaken for reassurance occurs frequently where doctors "reassure" thin, fragile patients that they will gain weight. They overlook the fact that for many of these slight, delicate individuals, their whole pattern of living has been to deny and reject the physical and to glorify the insubstantial, the spiritual, the exquisite.

Superficial or Defense Reassurance

When neurotic defenses against anxiety are beginning to break down, some therapists focus entirely upon restoring the old defense; they do everything to perpetuate the old neurotic pattern and aim to get the individual back to his former self. This is the "back-to-his-old-self" therapy. The superficiality of this kind of reassurance frequently goes unrecognized and is the basis for a great deal of current psychotherapy.

In connection with this defense reassurance the old concept of sublimation requires revision. Many of the non-analytic therapies, occupational therapies, music therapies, insofar as they adhere to the concept of sublimation, should be aware of the extent to which they may be re-establishing or fostering a pattern of defense which was on the point of breaking down. These particular forms of therapies, while at times essential, are not really reaching the fundamental source of anxiety and are therefore not fundamentally reassuring. Such sublimation provides defense reassurance and often subscribes to "back-to-the-old-self" therapy.

When an anxious patient says, "Doctor, everything is going to pieces," it should be realized that it is a neurotic defense that is breaking down, and that conflicts are on the point of emerging. Here the wise therapist will look for the neurotic defense and at first throw himself on the side of it but will recognize that this results only in superficial reassurance which is not the ultimate goal in good analysis.

A young man who came to see me about a rather pronounced stammer provides a helpful illustration. Members of his family were making strenuous efforts by argument, persuasion, threats and discipline to remove the stammer. It consequently became more aggravated, and the boy came to me under considerable tension. After about forty minutes, I had some slight understanding of what was really going on. I pointed out to him that, in some paradoxical way which he would come to understand, his stammer had become valuable to him, and he would find himself stammering less as it ceased to have value for him. This was reassuring, we might say, at a certain level. At least he felt he was not going to be forced to adopt new protective measures against his deeper anxieties. It also accomplished a deeper kind of basic reassurance because he sensed he was with someone who was trying to understand and he could feel that nature's attempt at cure was not being rejected. Also he could feel for the first time that the main focus was no longer on a stammer occurring in an individual, but that interest, both on my part and on his own part, had shifted to himself as a human being, who, among other things, had a stammer. Also my remark that he would cease to stammer when it was no longer valuable to him would reassure him that I would not perpetuate a neurotic pattern.

When the young college boy keeps saying that he's afraid he's going to fail in his exams, we notice this insistence on failure becomes stronger as he approaches the day of examination. There may be a way, perhaps, in which we can bring up the rather startling idea that this thinking of failure serves some temporarily useful purpose—especially because when we look at the record, we notice that he very frequently has had this fear before exams in which he has done exceedingly well. With one boy, the insistence on failure became stronger the more his father and mother told him they felt he would get through. On one occasion, when these reassurances were especially strong, the boy actually failed in his examination. He later said, "If only the old man would see me like the other guys—but I've always got to be somebody exceptional. Why can't he think that I might fail once in a while at something?" Obviously this kind of a father, what our culture might call the "reassuring father," is emotionally unable to make that change in himself which could say, benevolently and understandingly, "Well, maybe a couple of failures would help you in some way." Faculties at schools and colleges, who meet with this insistence on failure in a large number of young men and women, should give a great deal more attention to this whole problem and the various methods they are using to dispense reassurance.

A restless, intensely agitated teacher kept saying to me, "I can't get school out of my mind." I soon learned she really did not want to. She associates school with the children

and the principal. She feels that she can't control the children and that the principal is going to ask her to resign. She is really afraid she can't control her emotions. The children symbolize what she feels will get out of hand in herself. The principal represents the authority—the rigid, strict, neurotic authority in herself which would tend to keep conflicting and various emotions from becoming conscious and affecting her being. So, here, her inner conflict is being objectified. She is full of resentment and afraid her feelings will get the better of her. She finds herself, as time goes on, being more cranky, more angry, more irritable with the children and with others. Evidence that she is denying and repressing feelings is expressed psychosomatically; she says, "I feel that I have a clamp on my head. My nose gets blocked up. My ears are blocked up." It is not so much that she is cutting off something from the outside, but rather that she is cutting off something from the inside which is attempting to reach her consciousness. That is, her total involvement in conflicts would reach consciousness if she were not able to objectify the whole process.

A patient insisted to me that he was going to be arrested. He had a frightening fantasy of being locked up, and he admitted that he had a feeling that I might put him behind lock and key. "Of course, I know it sounds perfectly ridiculous, but I just can't get over the fear." I pointed out to him that, for some reason, the whole idea of being arrested, locked up, confined, restricted, was his own idea, and his insistence upon it indicated that, for some reason, he could not let the idea go. This man did not want to be "reassured that he would not be arrested"; on the contrary, he wanted reassurance that something would be arrested, that he would be able to arrest something in himself. A deeper anxiety had to do with apprehensions that his conflicting emotions were imminent and would get the better of him, that he would then be overwhelmed, that he would go berserk. I had to get it over to him, not in so many words, but by (1) moving the analysis in various directions to bring out in the past, in the present, and in dreams how intensive and extensive had been his conflicts over control, restriction, and confinement and (2) by showing him the literal and figurative implications of what he was saying and really wishing.

In this whole matter of reassurance, it would seem that what is one man's meat is another man's poison. Many of the occurrences and experiences of life which our culture would regard as reassuring, relieving anxiety, restoring confidence—such as success, promotion, good fortune, unexpected gifts—not only have had the opposite effect, but have resulted in serious anxieties, panics and suicides. How then, can we make any sense out of this confusion? This calls for a reconsideration of those human relationships which seem motivated by the highest virtues: thoughtfulness, consideration, kindness, common decency. We would say that love is reassuring and that perfect love casteth out all fear. Yet misconceptions of this whole philosophy are responsible for some of the most unfortunate mistakes in psychotherapy. Many of our seemingly virtuous attitudes are far from virtuous and, far from being reassuring, may actually increase the individual's anxiety. I have specially in mind here the urge to help people who are in distress, which, in so many, amounts to a *compulsion to reassure*. This compulsion to reassure is one of our greatest problems in modern medical and nursing therapy. Too often an opportunity to initiate treatment on a sound basis and to bring about a healthy orientation and perspective is missed because the over-anxiety of the therapist betrays itself and the patient is confronted with the therapist's compulsion to reassure. This results in the unconscious perpetuation of the patient's neurotic patterns. Such a therapist meanwhile has deceived himself and others by mistaking his compulsion to reassure for a virtue.

Psychoanalysis has shown the complex but effective ways to follow if we wish fundamentally to reassure our patients. These procedures are poorly understood by many of our psychiatrically trained colleagues and even more so by the general medical profession. Many of our procedures, in the course of basically reassuring certain patients, run absolutely counter to what many psychiatrists and the general medical profession conceive to be reassurance. It is en-

tirely the responsibility of psychoanalysis to present the whole subject in a way that will facilitate wider understanding together with a more extensive practice of those attitudes so essential to basic reassurance and real therapy.

Reassurance in Psychoanalysis

A clear understanding of the complex, intricate and pervasive nature of this whole reassurance problem will be gained if I call your attention to what is constantly being uncovered in the course of everyday analytic experience. I feel this is a necessary preface to my consideration of what constitutes basic reassurance.

An extremely interesting phenomenon which occurs in most therapeutic relationships is the patient's compulsive and insatiable need for reassurance. Praise, compliments, and approval ordinarily make one feel good—confident and hopeful and assured. With many patients, however, these only effect a very transient reassurance and then, again, more reassurance has to be sought. They wish to be continually reassured that the analyst is friendly, that he has a good opinion of them and that he likes them. There is a phase of almost constant *searching for signs of these reassuring attitudes.* The most trivial details are noted. Changes in the waiting room or the office, the analyst's greeting, facial expression, intonation of voice are all observed carefully for some indication that the analyst is friendly. Everything that is brought up during the hour has its deeper significance and value subordinated to this intense, insatiable and compulsive need for approval, or for proof of approval. This often occurs simultaneously with reassuring dreams in which the analyst brings the patient into his house or invites him to a picnic, or dreams in which the analyst and the patient are dining together. Waves of compulsive need for reassurance are often periodic and rather transient. They are frequently evidence of some forward step in the analysis. Destructive attitudes of the patient—exploitive attitudes, hostilities, resentments, tendencies to disparage the analyst—may be on the point of emerging into consciousness and conflicting with contrary attitudes. The patient himself tends to disapprove and reject these configurations, conceptions or attitudes which are arising and cannot admit them to himself. He invests the analyst with the same disapproval and anticipates rejection by the analyst. Also if there are destructive, disparaging attitudes toward the analyst, a patient may anticipate retaliation by the analyst. As long as there are these disparaging and destructive tendencies about to emerge, we can see how no amount of reassurance is helpful. The proof the patient may get today that the analyst is friendly has to be confirmed again tomorrow and the day after. For instance, the first glimmering awareness by a patient that he is unconsciously competing with the analyst, that he is attempting to defeat him, confuse him, etc., is frequently preceded or accompanied by a strong wave of searching for reassurance. Frequently, revelations of a sexual nature, either recent or from childhood, are preceded by a strong need to search for reassurance. At one level, the patient feels that because sex is regarded by him as dirty, ugly, taboo, anti-social, etc., he invests the analyst with his own rejecting attitudes toward the sexual experiences. In these situations there is also a somewhat deeper source which produces the compulsive need for reassurance. This stems from what the patient has been using sex for. With one patient, a strong need for reassurance and for guarantees that the analyst was not going to reject him preceded the revelation of a sodomy experience. The patient spoke of it as being disgusting and horrible and was sure the analyst could have no use for him. However, the deeper implications were that he was using people for his own pleasure, that in social and business intercourse he was exploiting others, and in his analytic intercourse there was an emerging awareness of the extent to which he was exploiting the analyst.

Then there are serious problems related to the patient's being unable to *ask for reassurance.* Among other things this involves admission of dependence on someone from whom approval is important. This conflicts with attitudes related to independence and dominating others. In obtaining such reassurance, therefore, the patient has to be

quite indirect and resorts to the trial-balloon method.

There are then great difficulties connected with *accepting reassurance.* To accept reassurance involves an admission of a still greater dependency on the analyst, which is often in serious conflict with attitudes that regard the analyst as weak, incompetent, and a vastly inferior being. Often, after some genuine reassurance has resulted from an interpretation of the analyst, or after some new emphasis which has been illuminating, this may immediately be followed by repudiation, contempt, scorn, or cynicism toward the analyst. In this connection we find the most indirect and circuitous strategies adopted to conceal the real source of reassurance from themselves and to attribute the feeling of well-being to something outside the analysis, some experience in the daily life, or something which they take care to point out they have discovered entirely independent of the analyst. Expressions of genuine appreciation, of gratitude toward the analyst occur late in all analyses and are associated with the resolution and the reconciliation of some of the most difficult neurotic conflicts.

For many, the conscious acceptance of reassurance involves them in binding obligations, and they dread a feeling of being forever indebted to the analyst. There are serious conflicts over what they often refer to as their "enslavement" if they accept any support or help or if they accept gifts. They are unable to be gracious receivers. For some, gifts are the opposite of reassuring and actually increase anxiety from which escape is sought. These conflicts which are brought closer to consciousness when the patient receives gifts are often resolved by keeping the gift while repressing all pleasure it brings.

We can see how a distrustful, contemptuous attitude towards affection, tenderness, sweetness, love can be a defense against accepting the reassurance. If the patient doesn't trust it, then he won't have anything to do with it. Behind such defenses we find that the patient really fears being completely carried away by his feelings and that he will be at the mercy of the conflicting hungers and desires that become conscious if he is "touched." One patient said he was afraid to taste or savor anything because he was afraid it would "seduce" him. This is similar to the "all-or-nothing" predicament of certain alcoholics who are completely unable to stop after one drink.

Kindness and thoughtfulness on the part of the analyst, which ordinarily one would consider reassuring, may have the opposite effect. Related to this are those instances in analysis where anger on the part of the analyst, whether real or imagined by the patient, may have a more reassuring effect than affection or kindness. This will occur in those phases where there is a great conflict as to whether the analyst is a human being, or an impersonal, invulnerable, dispassionate, highly objective observer. It is often the period when patients, struggling with their own detachment and lack of feeling, begin to wonder if the analyst has any feelings. Being wary, suspicious, and distrustful of affection, tenderness or sweetness, such patients feel that anger has something more genuine about it. This helps to explain certain instances where patients endeavor by many indirect and unconscious ways to make the analyst angry. They are wondering whether or not the analyst is responsive, and when the analyst admits that he is angry, they accept this anger as reassurance that the analyst is a genuine and responsive human being.

An interesting variation of the reassurance problem occurs in certain patients who express intense hatreds. It is important to see the value to the individual of this attitude of hatred. In many instances it is an attempt to keep away from conflicting feelings, to stiff-arm emotion, to avoid letting feelings get the better of him. Hatred is sometimes glorified. A young person once told me, "Hate is much more dignified than love—that crap." With this girl, whatever looked like love and affection was being resisted strongly because she was afraid of being swept off her feet completely. She was afraid of being a fall guy, a sucker, a push-over. I especially mention this paradoxical reassurance or relief of anxiety by maintaining hatred because we are so frequently confronted with our patients' insatiable desire to be reassured that you like them and their

ever-increasing demands for proof of being loved, that we cannot conceive that reassurance may be involved in those phases where patients are insistent upon hating and others hating them. A terrific insistence upon hating and being hated may be a last-ditch stand against a serious panic, or dynamically speaking, an abrupt emergence of serious conflict. Failure to understand the dynamics here and attempting to reassure the patient that people really do care for him, that no one hates him, or even a circuitous attempt at this time to introduce ever so subtly the idea of a friendly, affectionate world can be the very opposite of reassuring.

Permissive attitudes on the part of therapists are very frequently not reassuring. Many patients are afraid of freedom. They feel too weak to control; they put authority and control outside of themselves, although they will fight against it.

That a firm, predictable authority is reassuring is well known. A young patient of mine had always resented her parents' interference with her love affairs. When she and her boy friend were alone all day in the woods they remained very distant and no love-making took place; but at night, in the downstairs living room, with the parents upstairs in bed, the couple indulged in rather violent love-making. Here, the proximity of the authority was sufficiently reassuring so that the young girl could release her feelings and allow herself to become somewhat more intimate.

Reassurance in Dreams

In this brief paper on the whole problem of reassurance I can do little more than mention the great significance of dreams.

Many dreams are reassuring in that they show effective defenses against anxiety; other dreams show conflicting defenses against anxiety. A typical nightmare—being chased by buffaloes and being unable to run—dramatizes an intolerable inner conflict. From this the patient is relieved by: (a) awakening and resuming his pattern of conscious life which is in part a defense against the emergence into consciousness of total involvement in such a conflict, (b) continuing to dream and entirely removing the nightmare quality by lying down and letting the buffaloes ride over him. (This is expressed in waking life by submissiveness and letting others ride over him.); (c) continuing the dream and entirely removing the nightmare quality by rising off the ground and flying over the heads of the buffaloes. (Expressed in waking life by detachment.)

Again a repetitive childhood nightmare of being alone in a limitless void and falling through space was one night completely relieved by the patient dreaming he came to rest and "reached solid ground" in front of a well-known candy store. Here reassurance through sweetness—affection with oral overtones—is being expressed.

With another patient the nightmare quality was relieved by going into a room full of books. Here reassurance through intellectuality was one implication.

A repetitive nightmare of being chased by a moronic figure was always relieved whenever the patient could reach a certain weighing machine and stand upon it. This was expressed in waking life by a meticulous, obsessional pattern of life in which everything was "weighed carefully."

We can approach the analysis of a dream in the same way that we approach the analysis of a symptom. A patient not only has a dream but remembers it and brings it to the analyst, knowing that that dream is going to be analyzed. There may be some desire on his part to hold our attention to that dream—to discuss the elements in it, as if, at that time, the dream was an unconscious attempt to direct the analysis along lines that would have least anxiety for him, i.e., that would be most reassuring. The dream may indicate what neurotic defense is in jeopardy and what neurotic defense and defenses he wants you to support and protect. Our approach should be governed by the thought, "What elements in the total personality process should I support—the constructive elements and therefore basically reassure, or the neurotic elements and therefore superficially reassure?" An effective analysis is always bringing conflicts closer to consciousness. The patient protects himself against too sudden emergence by enlisting the analyst's attention in a way that will reassure him his defenses are approved and supported by the analyst.

Every move of the therapist has its reassuring or unassuring implications, and I am referring here to what supports or does not support the neurotic defenses as well as what supports or does not support the unique creative self which is trying to get free of neurotic entanglements.

Basic Reassurance

Generally speaking basic reassurance is in great part derived from the following: (1) the attitude and philosophy of the analyst; (2) his respectful attitude towards symptoms; (3) his differentiation between unhealthy conflicts and healthy friction; (4) his attitude toward helping the individual to participate in conflict.

Philosophy of the Analyst: The essential ingredients of a basically reassuring analytic relationship are Holism, Humanism, Homer (poetry), and Humor. Adherence to a belief in a holistic growth principle, and a genuine emotional appreciation of what this means is one great step toward introducing the first basic reassurance into therapy. This means complete refutation of a death-instinct philosophy and a complete refutation of a basic instinctivistic conflict in man. There is no instinctive conflict between body and mind, but in healthy growth we have our feet on the ground and our head in the clouds. As will be discussed in later paragraphs, the prevailing body-mind dualism which still pervades neurology and psychiatry is already a neurotic defense against awareness of our total participation in acquired inner conflicts.

It is basically reassuring for patients when they first realize that their intellectual and emotional potentialities are not inevitably, interminably, and wholly involved in building defenses against anxiety, and when they come to know that their anxiety is not determined by instinctivistic and therefore perpetual conflicts.

During every analysis, patients become aware of the falseness of the whole neurotic structure. They feel there is nothing genuine about them, no genuine expression of a real creative self. Needs for real reassurance at this time arise especially if there has been too much concentration on neurotic trends, because the patients are overwhelmed with feelings of terrific insincerity. For them this phase of analysis shows everything to be false, artificial, pretentious; they see all their giving and receiving on a bargaining basis—only Indian-giving. They either do what is expected or they react by doing what is not expected. Everything is reactive, contrived and underhand; there is no awareness of true generosity, spontaniety or graciousness. At these times, it is basically reassuring to indicate to patients that their compulsive giving and receiving, their need to give in order to get, their implicit bargaining and giving in order to get claims on others do not imply a lack of genuine, sincere attitudes and feelings, but, rather, that their genuine feelings are obscured by and subordinated to what is demanded and anxiety-driven. For example, a young man of a highly ethical, moralistic Boston family—an only son involved in an extremely close, possessive relationship with his mother—found himself prostrate with grief when his mother died. He had talked a good deal with me about what was demanded of him, what was expected of him. As far as he was concerned, everything in his life—everything he did and felt—was either what "was expected of him," or was a rebellion against that expectation. When his mother died, he said to himself, "These people know how fond I am of my mother—they will expect me to be prostrate with grief," and he accordingly was. But, at the same time he told me, he had a terrific feeling of insincerity. I had to point out to him that while there was some genuine grief for his mother's death, it was completely obscured by the grief he felt was demanded of him.

Attitude of the Analyst: The analyst who is basically reassuring is never neutral, cold, detached, or impassive. He is always emotionally involved with his patient but *not compulsively so.* He is responsive to the *whole* individual, which would include the unconscious determinants of the picture presented to him. He has to orient and address himself and respond to the whole individual, not just to the articulate periphery or some neurotic compartment. When a patient insists the analyst is impersonal and is constantly asking questions and insisting that the analyst's silence is unnatural and arti-

ficial, the analyst appreciates that the whole individual is not expressing himself and that the real individual that he wants truly to help is swamped, smothered, and strangled by his neurotic conflicts. If he does subscribe for the time being to a neurotic defense, he does it with his eyes open. The patient must feel reassured that the analyst is not going to take away his crutches immediately. As I have said before, for the patient an objective fear is preferable to panic and anxiety. With certain apprehensive patients who are able for the first time to express fear of something definite, we have to realize what this step involves.

As to the attitude towards symptoms, the following shows the orientation and application of a basically reassuring approach:

A patient presents an acute form of writer's cramp. The family doctor told him he would get over it when it was first noticed a couple of weeks ago, but it seemed to get worse and worse. Did the family doctor know the value of this writer's cramp to the patient? Had the point of view that certain symptoms have value ever occurred to him? The individual is overtly expressing a conflict locally that is involving his whole being. The question here is what is going to be most reassuring to the individual, and how can we best proceed toward a genuine and basic reassurance. A conflict is involving his whole personality, but it is only coming through consciously in one localized area of his being. Just the mechanical, physical elements involved in writing are shown to be in conflict. This localization of conflict is nature's way of relieving anxiety, of bringing about some reassurance. When the patient presents such a symptom to the doctors, he wants them to focus on it. At first he does not want the doctor's interest to extend beyond the localized conflict. But while there is this limitation of focus on the localized area, this patient does not want to be reassured that he will get rid of it. It is reassuring, then, to let him talk about it, and quite the opposite to tell him to get his mind off it, to stop thinking about it. He does not and cannot let himself become aware of his total involvement in conflict. So then in our efforts to bring about basic reassurance by showing him that his whole personality is involved, this, too, has to be done slowly. Many a psychiatrist does harm in trying too quickly to get over to the patient that his real trouble involves his whole personality. We know this to be true, but the admission and the acceptance of this has to be an extremely gradual process.

Attitude toward conflict: The avoidance of all friction—the avoidance of all conflict—is basically unassuring. I believe that basic reassurance is relative to the extent that the patient allows himself to become conscious of his total participation in conflicts—in other words, to the extent that he finds the strength to feel his whole being in conflict. This would be to face and feel consciously the gross contradictions and hypocrisies in himself.

It is helpful to conceive the internal situation as something like this: A conflict has been brought close to awareness. The patient avoids consciousness of his total involvement in this conflict, which is an intolerably anxiety-filled experience, by detachment—by repression of the conflict. Of our neurotic patient, we can say truthfully, "You are a whole person, but you cannot admit it," because this necessitates awareness of total participation in conflict. He must gradually be brought to accept consciously this total participation. Certain localized expressions of the conflict may remain in consciousness. The conflict remains active, however, and is expressed unconsciously in all his relationships with himself and others. Therefore the individual cannot basically feel whole or admit that he is whole. This inadmissability or non-acceptance of being whole—unwholesomeness, we might call it—cannot help but be accompanied by feelings of weakness. Out of this feeling of weakness comes the feeling that the individual would be at the mercy of his feelings, that he does not have strength to control his own feelings, or he does not have strength to control his emotions.

To assist the patient consciously to accept his total involvement in conflicts and not allow him unconsciously to keep them localized to one structural or temporal area of his total life pattern, we have gradually to bring into awareness these conflicts as they express themselves in the past, in the present, in dreams, and in social life. If, when

the patient is bringing up conflicts from the past, we can be showing their continual relationship with the present, this has fundamental reassuring value. When we are able to show that what took place on a perceptual and tangible basis in childhood has its analogy to what is going on symbolically and figuratively in the immediate present, this gives the individual a wider and broader basis of awareness and therefore is basically reassuring.

There are certain terms applied to memory such as recall, revival of memory, which carry the erroneous implication that elements previously inactive or dormant now become active. What really happens in memory recall is that our past, which is always alive and active within us but acting upon and influencing our lives unconsciously, is brought to our awareness and is now merging consciously with the present. This enlarges our consciousness, increases the extent of our conscious personality. It is not so much that being healthy we have therefore a greater memory and know and feel a wider extension of ourselves, but rather because we feel and accept and admit a wider extension of ourselves in the past and in the present *with all our conflicts* that we feel healthy. Memory recall, particularly memory of conflicts, is basically reassuring—it means that we are admitting more of ourselves.

When certain patients are on the verge of panic and there are dreams in which the patient brings up the past, I have found it reassuring to follow up these leads and to keep the patient talking about these past events relating to the dream. The conflict which is on the point of emerging and the source of serious anxiety is thereby attenuated; it is certainly not evaded.

We have to pay more and more attention to the memories of conflicts in childhood. It is conflicts that are repressed or dissociated rather than memories per se. Because the child lives mainly at a perceptual level, more and more of the conflicts at the earthy, sensuous level must be made conscious. Here, there is some similarity to the Freudian procedures. I would like to say that I disagree with the reasons Freud gave for emphasizing childhood experiences, childhood sexuality, interest in excrement, etc., but I feel more and more that this phase of the four-dimensional life pattern must be brought out and linked with the present, with the dream life, with the relationships with the analyst, with the experiences in the extra-analytic relationships. I am led to think this way because I strongly feel that the patient's consciousness of his total participation in conflict has to take place eventually and we must not allow the conflict to remain localized in any one temporal or structural area.

The microcosmic process during effective analysis is analogous to the macrocosmic phenomenon of the Renaissance. The resurgence of creative effort, the sudden development and expansion of man's awareness, man's full personality, during the Middle Ages, followed upon an acceptance of the past and a merging of the past with the present. There was at last an inclusion of what was earthy and worldly in the total consciousness, all of which previously had been repressed by the rigid orthodoxy of the Dark Ages. Humanism asserted itself as it must do in all successful analyses.

There is then something about getting down to earth literally and figuratively that is a means of basic reassurance. We can return to the earth, return to sleep, to the past and to darkness not as an escape, but as a means of going into the darker reaches of ourselves, to extend our awareness, to get closer to ourselves. Sleep is not primarily an escape, although it can be used as such. We go into the darkness to get light, just as the French scientists—the Curies—went into the darkness, the primitive, primordial darkness and mud, into the black pitch of night, to get radium. In sleep, the present merges with the past and the past with the present. Sleep is basically reassuring but where there are serious conflicts, sleep can be an escape—that is, a superficial or symptomatic means of reassurance through return to the past, a return to dreams. In this category, we have the concept of the return to the womb but determined by anxiety and not by instinct.

The greater the degree of humility, the less the need for reassurance, and the more basically assured this individual will be. Humility means down to earth, means on the earth, as distinct from humiliation, which

means being brought down to the earth.

Under basic reassurance we have to include that reassurance that comes from what we can call accepting the child within us—that is, accepting the crude, unrefined, inchoate elements in ourselves. This is all repressed in the repression of childhood conflicts.

There is some connection between basic reassurance and the ability to laugh at one's self, to laugh at the awareness of contradictions and discrepancies and hypocrisies in one's self. We find this laughter coinciding with periods of insight or extended awareness. Such laughter in analysis is very often a sort of a laugh-cry, a laughing, crying, jittery feeling and is really a physical manifestation of total involvement in conflict. There is no doubt that related to this, there is a new accretion of strength and some basic lasting reassurance. Certainly, the willingness to engage, the willingness to be consciously engaged in the whole conflict adds an additional quota of strength and reassurance. We must include here all those feelings of basic reassurance that come from a feeling of being more whole, a feeling of being more wholehearted.

From a patient undergoing analysis I would like to illustrate the processes and feelings operating in the two forms of reassurance that I have mentioned and described: "defense reassurance" and "basic reassurance."

First, the defense reassurance took the form of objectification of anxiety. The patient said, "Instead of terrified numbness, I feel sick. I'd rather feel that way." "I have pains in my stomach and fix all my fears on them, instead of what I am really afraid of, and that's my feelings." Here we see the objectification of anxiety which is already a step towards relief. This was the same patient who said to me, "Oh, if I could only have something concrete to be afraid of."

With this patient it had been part of her escape from involvement in conflicting feelings to resort to a high degree of intellectual detachment with complete denial of the physical. It was almost as if she were physically non-existent. Yet externally, what was delicate, fragile, and physically harmless was the basis of one of her greatest phobias. She was afraid of moths. She was not afraid of any insect that had a sting like a wasp, hornet, or bee. She could handle these quite effectively. This patient was really afraid of the intangible, her intrapsychic conflicts and emotions. She was trying to objectify this anxiety. She was also afraid of bats, and in her more recent dreams, she carried an old repetitive nightmare to something like a conclusion. Previously, when she dreamt of bats, she always woke up before they came to her. Last year, however, she dreamt she took the bat in her hands and grappled with it, came to grips with her emotion, you might say, or with her conflict. Then more recently the bat came to her and struck her right in the chest. It lay on her chest and fluttered and she awoke with her heart fluttering violently. This dream, while superficially a source of considerable anxiety and fright, was basically a source of lasting reassurance. She said, for the first time, she knew and was able to "take to heart" what she was afraid of—her conflicting emotions. She had wished for something concrete outside herself to be afraid of, and this wish seemed to express itself in her dreams and in reality. What actually was real here was her physical involvement in conflicting emotions. This she tried to objectify. As long as she denied and would not allow the internal physical realities to frighten her, then she could get no reassurance from internal physical, substantial sources.

This patient frequently complained of pain, numbness or paralysis of her legs. Whatever is supporting us, holding us up and is the source of our strength must have some connection with assurance and reassurance, hence the importance of the lower limbs and the various psychosomatic symptoms in the lower limbs which frequently become manifest when conflicts about self-assurance and reassurance are closer to consciousness.

Conclusion

In view of the confusion and misunderstanding that prevail regarding reassurance and the somewhat haphazard, ill-considered dispensing of so-called reassurance by those desirous of helping others, this is an appropriate time to review the whole subject.

I realize the great over-simplification in this presentation, and I would like to have it understood that I do not wish to advocate here any specific techniques in reassurance. Where I have described techniques and procedures, I have tried to give the general trend of attitudes that I feel should prevail with greater frequency, rather than specific prescriptions. From those everyday clinical situations which invite reassurance, I have tried to illustrate how some of the greatest errors are made and where some of the greatest opportunities for real help have been missed.

A more careful consideration and understanding of the dynamics involved in the whole process of reassurance will help us toward a better clarification of our goals in therapy. If we take the literal definition of reassurance—that is, to free from fear, care, and anxiety, to restore confidence, we could say that this is the goal of all therapy. I hope it has become obvious, in the course of this paper, that relieving anxiety can be one thing, while dispelling or removing the causes or the determinants of anxiety can be something else. It is more along this latter line that genuine basic reassurance takes place. To put it in other words, in the microcosmic struggle and conflicts, a peace-at-any-price procedure may be followed with some temporary or transient reassurance, and this may indeed be necessary, but the high price that is paid will only purchase what is an illusion of reassurance.

The more it can be brought to consciousness that acquired inner conflicts involve the whole structural and temporal being, the greater will be the degree of basic reassurance.

CONSTRUCTIVE FORCES IN DREAMS

FREDERICK A. WEISS *

THE DREAM is a "royal road to the unconscious."[1] Where this road leads will necessarily depend on what we expect to find at its end—on our concept of the character of unconscious emotions. If the unconscious is considered to contain only irrational wishes for libidinous, aggressive, or destructive satisfaction, then dreams can express no more. An unconscious which harbors no rational, constructive forces cannot be expected to express constructive forces in dreams.

Horney emphasizes in her recent work[2] the existence and unconscious activity of constructive forces also in the neurotic. These forces, which move the patient toward emotional health and genuine growth, are strengthened and mobilized in the process of analysis.

Poul Bjerre, a Swedish psychoanalyst who followed Freud on his way from hypnosis to psychoanalysis, gives a pertinent description of the impact produced by an exclusively irrational and destructive concept of unconscious motivation:[3]

". . . It means that the more we succeed in penetrating all surface phenomena and reaching the essentials of psychic life, that is those of life as a whole, the oftener we come across powers inimical to ourselves; and finally we fall, a helpless prey, into their hands. During the Middle Ages these powers were called demons. We call them instincts. The difference in terms is of little moment. . . . True, we can rear the structure of consciousness on the volcanic ground of the unconscious. We can live and act in this structure, but we can never feel secure. And what is worse, we can never feel free and content. In a thousand circuitous ways the repressed instincts influence our conduct, disturbing, arresting, and producing disease . . ."

Bjerre rejects this pessimistic view of psychic life. Analytic experience as well as life experience shows that there are "useful, creative, life-affirmative forces at work in the unconscious. Dreams are one of their most important expressions."

In his book *Dreaming as a Curative Process of the Mind,*[4] Bjerre deals with the clinical manifestations of this phenomenon. He starts by comparing our reaction to a psychic trauma with that to a physical trauma: A man is being insulted. Immediately a re-

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[1] Freud, "On Psychoanalysis," *Am. J. of Psychology,* Vol. XXI, 1910.

[2] Horney, *Our Inner Conflicts,* New York: W. W.Norton & Co., 1945.

[3] Bjerre, "The Way to and from Freud," *Psychoanalytic Review,* Vol. XII, 1925.

[4] Bjerre, *Das Träumen als Heilungsweg der Seele,* Zurich: Rascher, 1936.

action sets in. Even if no movement, no word, not even a change of color betrays what is happening within him, unconscious forces are mobilized to neutralize the effects of the insult. The psychic trauma exerts an effect on the psyche analogous to that produced by the physical trauma on the body. If a splinter gets under one's fingernail, one immediately takes consciously planned measures to remove it. Simultaneously, however, spontaneous natural forces are being mobilized, entirely independently of our conscious intentions, to stop the bleeding, prevent infection and promote healing.

Constructive forces exist in our unconscious, the action of which is similar to the activity of the artist who creates a poem, a symbol, a drama, or a painting from the accumulated abundance of chaotic material. This creative process, which leads from chaos to integration, from death to renewal, also takes place in the act of dreaming. Dreams have a definite "biologic-synthetical function," the main goal of which is the "assimilation" of emotional experiences.

The tension of being awake keeps our attention fixed upon matters which preoccupy us at the moment. During the relaxation of sleep, our perspective suddenly widens, and we become aware of feelings and experiences which had been ignored or repressed. Of special curative significance is the unlocking and recapturing of the vital sources of the past.

In the dream the conflict between past and present, between death and renewal, becomes intensified. Therefore we often meet symbols of death and of renewal side by side in one and the same dream.

The curative process of dreaming leads the patient through twelve successive stages of emotional development. These are not sharply separated from each other but may merge in every single dream. The dream process starts with:

1. Creative Formation ("Gestaltung"):

Here the dream provides the dreamer with a symbolically condensed picture of himself or of his basic conflict. This self-presentation may already be accompanied by a feeling of liberation. To be confronted with one's real problem is a helpful experience and the prerequisite for a constructive solution.

2. Connecting:

Here the dream actualizes more or less "forgotten" experiences of the past. This process takes place not to repeat them passively (in a "repetition-compulsion"), but to connect them actively with the present and to promote the growth of the individual.

Connecting has two functions: The first is to draw unintegrated experiences of the past into the "stream of life" and to work them through. The second is the actualizing of constructive experiences of the past, to overcome repressions and inhibitions of the present.

(This mobilization of constructive experiences of the past in dreams becomes a highly valuable therapeutic factor in the analysis. Nothing is more encouraging for the patient than to be made aware of the existence and activity of constructive sources *in himself.*)

3. Awakening:

"Awakening" here refers, as Bjerre states, not mainly to the awakening of repressed sexuality. This is too limited a goal. The patient must be awakened to a deeper awareness not so much of his instincts as of his individuality, his "better self" (we would say: his "real self") and the meaning of his life.

In this group of awakening dreams, Bjerre includes dreams which warn the patient against an imminent danger. He focuses on dangers coming from the outside, from others, whereas we often observe therapeutically significant dreams which warn the dreamer against danger originating within himself—from his own neurotic trends.

4. Decision:

In dreams of this type a decision is made between two alternatives. One is accepted as reality while the other is rejected as impossible. (We would say: The decision is made between a neurotic and a healthy attempt at solution.)

Bjerre states correctly that important decisions in our lives are made not by submission to the supreme court of a superego, but guided by the constructive forces in our-

selves. Dreams of the decision type sometimes assume a predictive character. (We would explain this with the fact that they reveal to the dreamer significant character trends which mould the pattern of his life and make his "fate."

The next three stages—*Objectivation, Separation,* and *Negation*—have the function of "eliminating the non-assimilable material." Emotional life, according to Bjerre, is possible only when the past dies off and we can free ourselves from the dead. The old concept of repression is seen as misleading because it does not distinguish between the repression of more or less destructive instincts and the repression of constructive forces in ourselves, caused by prejudice and emotional confusion.

This concept—that constructive forces (we would include here: affection, healthy self-assertion, the wish for self-realization) are also often repressed in the neurotic—is clinically highly significant and in agreement with Horney's constructive theory of neurosis.

The first stage of the psychological elimination process is that of:

5. Objectivation:

Some unhealthy part of ourselves becomes disconnected. It acquires the quality of a detached object and can now be treated as such. Alcoholics in their dreams frequently meet drunkards in the street. According to Bjerre, that means they objectivate their urge to drink and try to separate it from their selves. As long as they are helpless victims of their urge, they are, as it were, identical with it. By the objectivation in the dream, this identification is being dissolved. The "alcoholic self" and the "real self" become separated, and the final break between them becomes possible.

6. Separation:

This stage of the dream process reflects the attempt to free oneself from a disturbing or painful experience. In the language of the dream, this is often expressed by placing the disturbing person or factor at a proper distance or by removing oneself from it.

Bjerre here includes dreams in which we create a distance between ourselves and a person toward whom we feel hostility by tearing our enemy down and elevating ourselves to a grotesque degree. From our viewpoint of character analysis, we would evaluate such a dream in rather different terms: not as a step in the direction of emotional health, but as the expression of a neurotic need for vindictive triumph and self-glorification.

7. Negation:

This stage represents the climax in the phase of elimination. "What is dead has to be buried. Where the past is in the way of the future, the past has to be overcome." The death of those elements which have to die is often symbolized by pictures of violence. The dream pushes somebody down an abyss, has him witness an execution, drowns him with his ship in the ocean or kills him in a train or car accident.

Dreams of this type are therefore not always expressions of violence, aggression, or sadism. They often symbolize the death of emotions which *deserve* to die. The death of a person may represent the death of an unhealthy emotion in us which was connected with that person. (We would say: the end of a neurotic relationship—for example, of a morbid dependency.)

The successful negation of life-inhibiting (we would say: retarding) forces is often accompanied by an ecstatic experience of increased vitality and liberation. The past is no longer in the way, and the road is now open for the future. Dreams which reflect this experience are included in the next stage, that of:

8. Uplift:

In dreams of this type we feel the wall disappear which lies between ourselves and our goal. Perspectives are opened up which had been invisible before. Uplift dreams are sometimes induced by the elevating effect of a great work of art.

This constructive state of uplift must be distinguished from the by-no-means constructive state of pseudo-ecstasy which one tries to induce in oneself artificially if one suffers from the impact of depressing emotions. This pseudo-ecstasy represents merely an attempt to escape from truth and reality

and serves a need for emotional intoxication seen most characteristically in the alcoholic. He feels at the same time the need for the uplift and his incapacity to reach it by his own effort. I have observed dreams of this pseudo-ecstasy type in detached patients with strong tendencies to living in imagination after traumatic or humiliating experiences or after analytical sessions which had brought insights still too difficult for the patient to accept.

The liberation from the paralyzing past may take various forms. An important phase is the next stage:

9. IDENTIFICATION:

We are inclined to identify ourselves, Bjerre states, with the human being who has suffered more than we have or who is stronger than we are. We need the experience of an inner community with personalities who become symbols of our own growth. The dream often uses historic personalities to express emotional drives of the dreamer among which Bjerre especially emphasizes the drives for power, glory, and recognition.

This mechanism of identification, in my opinion, has by no means always a constructive significance. Authorities appearing in the dream are often still crystallizations of neurotic trends and of neurotic attempts at solution. Their real significance has to be found in each individual analysis. The appearance of Franklin D. Roosevelt in some of my patients' dreams symbolized the need of dependent persons for a trust-inspiring, benevolent authority but sometimes also the constructive feeling: One can be paralyzed and yet be great and fully recognized.

The dream work gradually reaches the goal of assimilation in the last three stages.

10. RE-EVALUATION:

To a new experience requiring a radical readjustment, we often respond first with defense and anxiety. We do this even if it concerns a basically good and constructive experience. A woman afraid of pregnancy, as though it were a terrible catastrophe, may later experience it as a liberation of her deeply hidden feelings and as a genuine growth of her personality. Re-evaluation leads to the achievement of a new perspective. What appeared dangerous before, now appears conquerable. What appeared bad and caused (neurotic) guilt feelings is seen in a new light and the guilt feelings vanish. The stimulus for such a re-evaluation dream frequently comes from a remark the analyst has made or an insight the patient got during the analytical hour.

An important type of re-evaluation is the relinquishing of a scapegoat which one has blamed for all the misfortunes of one's life. This may be very painful at first, but the pain is not in vain. We would call this phenomenon the giving-up of an externalization which blocks the road to any constructive change.

Re-evaluation is not enough. The pain often remains after the sting has been removed. A more penetrating process has to follow. It is the stage of:

11. TRANSFORMATION OF FEELING ("UMSTIMMUNG"):

Bjerre considers this stage the center of his entire concept. The transformation of feeling may take place slowly, step by step, or in a split second. Traumatic experiences, such as conflicts with the parents which created deeply repressed hostility, may remain unassimilated for years—therefore in urgent need of this transformation of feeling. The overcoming of such old hostility may be symbolized by dreams in which old tensions with the father reappear and become resolved. (We would say: dreams in which the patient's relation to authority is freed from ambivalence and compulsive elements.)

Bjerre's description of the transformation of feeling corresponds most closely to the phenomenon of a basic emotional insight, in contrast to a merely intellectual understanding. The result is a lessening of the alienation from our real selves which makes possible a genuine acceptance of ourselves and of others.

The last stage of the dream process is that of:

12. ASSIMILATION:

We have undergone an experience difficult to assimilate. We obtained insight into feelings not understood before. Assimilation

is more than either acceptance or negation. We may accept an experience out of cleverness and opportunism, but then it remains in us like an encapsulated foreign body. Emotional assimilation requires sacrifice, the giving up of something which previously possessed a special value for us. (We would say: the giving up of our idealized image, of our neurotic claims and neurotic goals.) Characteristic of successful assimilation is the fact that the assimilated experience enters the "stream of life" so completely that it no longer interferes with the process of inner renewal.

Bjerre's concept of assimilation comes closest to what we would call "integration." But his whole concept is too much concerned with the assimilation of traumatic experiences and not with the integration of the patient's character structure. Nor does his goal of assimilation include the capacity to form healthy interpersonal relationships. Among examples of successful assimilation, he mentions people who became able to live in a state which we would describe, at its best, as "successful detachment."

An attempt to compare Bjerre's stages in the dream process with our own concept of the dynamics of dreams follows:

1. Creative formation—presentation of self and basic conflict.

2.–4. Connecting, awakening and decision —stages in the mobilization of the constructive forces; beginning of awareness of the real self.

5. Objectivation—gaining insight into the neurotic structure.

6. Separation—confrontation of the neurotic and the real self.

7. Negation—overcoming of the retarding forces.

8. Uplift—feeling of inner liberation.

9. Identification—lessening of the alienation from the real self.

10. Re-evaluation—giving up of externalizations.

11. Transformation of feeling—emotional insight; moving of "center of gravity" to self.

12. Assimilation—giving up of neurotic claims and neurotic goals; genuine self-acceptance; integration.

Critical Evaluation

Bjerre's work represents a significant contribution to the development of dream interpretation:

1. It emphasizes the existence and activity of constructive forces in dreams.

2. It overcomes the wish-fulfillment concept, the sex-centered orientation, and the static quality of symbolism contained in earlier dream theories.

3. It considers dreams as attempts at solution. But our goal is a concept of dreams which forms an integral part of a dynamic psychology of the total character structure and which permits the most constructive use in psychoanalytic therapy. From this holistic viewpoint, Bjerre's concept still suffers from several basic deficiencies:

1. His one-sided emphasis on the curative forces gives his system a teleological and vitalistic aspect. Dreams are neither exclusively neurotic as Freud assumed nor exclusively curative as stated by Bjerre. Freud,[5] consistent with his concept that everybody is involved in the conflict between instincts and ego and that the dream is an expression of this ubiquitous conflict, states: "The healthy man, too, is . . . virtually a neurotic. But the only symptom that he seems capable of developing is a dream."

While Freud considers the dream a neurotic symptom even in a healthy individual, Bjerre sees it as a symptom of health in the neurotic. Both concepts are one-sided. Constructive forces moving toward health and retarding forces striving to maintain the neurotic pseudo-structure are both active in him. Their interplay finds its expression in dreams. Only this dialectical concept enables us to make constructive use of dreams in analytic therapy.

2. Bjerre over-emphasizes the role of the past. He sees the conflict as one between the past and the present. The past, however, enters the conflict not as the past, but as a dynamic emotional force which is part of the present. Only the analysis of this dynamic factor opens the way to a constructive solution of the conflict.

3. Bjerre's therapeutic goal remains

[5] Freud, *General Introduction to Psychoanalysis*, New York: Garden City Publishing Co., 1920.

limited. It is the assimilation of traumatic experiences, not the integration of the character structure. But while the traumatic experience originally contributes to the formation of the patient's neurotic character structure, it is this same character structure—not the traumatic experience—which later acts as a constantly traumatizing factor in the patient's life.

4. The dynamic concept of a total character structure, which is missing in Bjerre's system, provides a reliable therapeutic basis for the interpretation of dreams.

Dreams and Character

The close connection between character and dreams was observed with remarkable clarity by Schopenhauer[6]:

"In dreams a hidden force directs all events.... This force basically cannot be any other than our own will which, however, in this case does not enter our consciousness. ... In his dreams everybody acts in complete agreement with his character."

We see the neurotic character structure today no longer as the inevitable result of instinctual conflict but as the manifestation of a distorted emotional growth. In an emotionally healthy environment, a strong, solid self grows—to form later the core of a free and spontaneous personality able to realize its potentialities and to relate itself constructively to others. In the poor soil of an unhealthy emotional environment—unhealthy due to lack of affection, to rejection or humiliation or due to over-protection with over-expectations and favoritism—only a weak self is formed. As a defense against basic anxiety, it develops compulsive neurotic trends and an unreal idealized image. This defense structure, built up for emotional survival and for protection against the inner conflict, represents the *pseudo-self*. The neurotic becomes more and more alienated from his *real self*, the only source of true strength and growth.

Two sets of forces operate in the neurotic: (1) *retarding forces*, which act to maintain the *status quo* of the pseudo-self, paralyze the real self and create hopelessness; (2) *constructive forces*, which strengthen the real self. They lessen anxiety and compulsiveness, gradually loosen the rigid defense structure and free the energy—which was bound in it—for constructive growth.

Having lived with his neurotic structure for years, the patient experiences his neurotic pseudo-self in spite of all pain, fatigue, unhappiness and psychosomatic symptoms, in spite of the impoverishment of his whole personality, as the only available self. The imitation of life which he lives is the only life of which he can conceive.

Dreams—the Pacemakers of Constructive Forces

It is often in dreams that the patient first becomes aware of the existence of another, healthier self within him which, however weak it is now, can grow; and of another, healthier life which, however far away it may now appear, might be realized. Thus dreams often become the pacemakers of the constructive forces.

Dreams may be considered as attempts at solution of inner conflict. Kelman[7] showed how in the course of analysis neurotic and irrational attempts at solution change into healthy and constructive ones.

Even before dreams reflect definite attempts at solution, they may fulfill a highly constructive preparatory function. One group of dreams, occurring often in the beginning of the analysis, presents the self and the basic conflict.

These dreams, resembling those of Bjerre's stage of "creative formation," give us a symbolic, condensed picture of our feelings about ourselves: how we inflate or devaluate ourselves; our relationship to others; our self-effacing or vindictive trends; the precarious situation into which we have maneuvered ourselves. They often dramatize our basic conflict or one aspect of it.

Bringing us face to face with our unhealthy *status quo*, such dreams pose the problems which confront us and make us aware of the need for change. They often show the self-defeating effect of neurotic trends:

A vindictive patient dreams of driving a

[6] Schopenhauer, *Parerga und Paralipomena*, Leipzig: Brockhaus, 1850.

[7] H. Kelman, "A New Approach to Dream Interpretation," *Am. J. of Psychoanal.*, Vol. IV, 1944.

competitor in front of him towards a wire mattress which is electrically charged; however, not the competitor receives the shock, but the dreamer himself.

A compliant girl, who for years had enjoyed the benefits derived from an extreme dependency on her mother, dreams: "I am a guest in a friend's home. I am sitting in the kitchen. There is a huge statue of a woman and my friend tells her to serve coffee. She does so and even takes the garbage out into the hallway. I exclaim: 'Isn't this a marvelous gadget!' At this moment, the statue falls on me and almost crushes me."

A man who has lived almost exclusively in his imagination with a grandiose idealized image and has tried to avoid any active responsibility which might have endangered his image, dreams: "I give my penis to my wife and feel relieved by it. While she holds it in her hands, I see it wither. I become afraid that it will no longer be useful when I want to put it back again on myself." At the time of the dream, the patient recognized the self-defeating impact of his irresponsible, passive-dependency attitude.

A more dynamic type of self-presentation dream dramatizes the conflict by showing a split image: real self versus pseudo-self. These dreams usually occur later, in the "in-between" stage of the analysis in which the patient already realizes that the *status quo* has become untenable but cannot yet see the way to constructive change. The juxtaposition of the two selves often leads to still rather mechanistic attempts at solution which consist in the removal or killing of the pseudo-self. Such dreams, corresponding to Bjerre's phase of elimination, are partially constructive because they evidence the fact that the picture of his neurotic pseudo-self is crystallizing in the dreamer.

An artist who lived a life based on the claims of "a man of distinction" and on success derived from Hollywood glamor dreams that it is his unavoidable duty to shoot Humphrey Bogart. He does it in the dream without any strong emotion. He has recognized that on the way to his real self he must get rid of "the Bogart within himself."

The fact that constructive forces are beginning to overcome the retarding forces of inertia and hopelessness finds expression in dreams which show that growth and change are possible. Such dreams are accompanied by a sudden decrease of anxiety because they reflect the insight that there exists a way out of the neurotic dilemma. They may consist of nothing more than a general picture of growth:

A patient who was very skeptical about the possibility of inner change dreams about a tulip and adds: "The interesting thing about this plant was its power of regeneration."

Or such a dream may dramatize the process of change itself:

A patient, who because of strong dependency needs has shirked all active responsibility and has led an extremely passive life, experiences the limitations of his status and the change in the analysis in the following dream: "A blind colored man is kept in prison with his legs chained together. He lives a not too unhappy, but very restricted life. One day he becomes seriously ill and has to be taken to the doctor. He is stretched out, face down, on a table. The doctor gives him a sort of osteopathic treatment, explaining as he does so that he is reviving and loosening up certain muscles. As the treatment continues, the prisoner grows lighter in color, his sight comes back to him, and he becomes *me*. I felt free."

This dream still reflects a magical and passive concept of analysis. But the patient sees the impoverishment of his life by the neurosis. He experiences that change is possible, that a prisoner can become free and a blind man regain his sight. Thus the dream expresses and stimulates hope. (Incidentally, the use of the change of color as a symbol in the dream reveals that even our unconscious emotions are not immune against cultural conditioning.)

The most important constructive inner change, the lessening of the alienation from the real self, is often reflected in a dream and may actually be set in motion by it.

A woman under the pressure of a perfectionistic idealized image has become filled with violent self-contempt and is severely alienated from herself. She has rejected herself to the degree of making several suicidal attempts. She resents being a woman and she rejects "body and sex." At the mere men-

tion of these words during the analysis she displayed strong reactions of disgust. Now she dreams:

"I was beside a crib in which lay a little girl who was just waking up. I had a very strange feeling. I loved her very much and it did not frighten me. I picked her up, held her and loved her. I asked her whether she had wet her bed and she said she had not. But I felt it would not make any difference to me whether she had or had not. I took her into the bathroom, and there she started to urinate and she filled a big pot just to the brim, which was remarkable. I kissed her all over, from the forehead down to the lower body and finally on the sex organs. A year ago I would have wanted to kill her because she was a girl. I would have felt horrified and disgusted. But she had a lot of personality. Passive but quite outgoing. I had a new feeling of happiness."

The feeling of happiness which the patient has in this dream reflects that basic emotional change which Bjerre calls "transformation of feeling." The love which she feels for the girl, even if she has been "bad," shows a lessening of the extreme demands she made on herself. That the girl "fills the pot just to the brim" still shows remnants of her perfectionism. But her kissing of the girl's body "down to the sex organs" indicates the beginning acceptance of "body and sex." Her acceptance of the child "although she was a girl" and her statement that "she had a lot of personality" makes this dream a pacemaker on her road to a genuine acceptance of her real self.

In dreams dealing with the analytical situation we can also observe the work of the constructive forces which change the patient's role from a passive to an active one. Dreams in which the patients see themselves lying on the operating table, leaving the doctor's office with small laundry slips attached to their clothing as though they had just left the laundry, as docile pupils in a classroom or as resentful inmates of a prison later change into dreams in which the patient becomes the analyst's active partner in the analytic process. It is of decisive therapeutic significance to know that there are constructive forces available even in the severely neurotic patient. It is the task of the analyst to mobilize them. In this process of inner liberation and real growth, dreams are among our best helpers.

CHILD ANALYSIS AND HORNEY THEORY

NORMAN KELMAN*

In this paper I wish to regard child analysis within the framework of the Horney theory. While the spirit of that theory is of greatest importance for the treatment of all patients, it has specific positive value for work with children. A full critical evaluation of other psychoanalytic approaches will not be made, although some comparisons with Freudian theory and method will be indicated.

Some special problems arise in the treatment of children. The first is that the decision to seek analytic help does not come from the child, but rather from the parents or some other authority such as the school or the Children's Court. This would seem to make the child a pawn, the object of coercion. It has been pointed out that the child rarely suffers from his neurosis—rather it is the environment that is disrupted by the child's illness. Because of this, it is felt that motivation for cure is absent, and the analyst is deprived of a valuable ally.

The second problem is that the child, particularly the young child, does not as a rule have a facility with words, nor the capacity for conceptualizing or connecting ideas in verbal form. This is less true with adolescents or with certain children whose language precocity may be the expression of a mental development precipitated by inner conflicts.

A third problem is the child's refusal or inability to associate freely. He seems to lack an interest in self-examination and the ability to observe his thoughts for subsequent evaluation. Thus the analyst is deprived of an important investigative tool. Fourth, children tend to act out, to be more expressive manually or physically. This means that in the course of analysis, the tendency to externalize difficulties and to take direct action on the environment would diminish intrapsychic tension.

The child's realistic dependence on adults for his very existence adds a fifth problem to the treatment situation. Because of the still existing parent-child relationship, another important therapeutic tool in classical Freudian analysis is absent—the development of a transference neurosis, whereby the child projects his unconscious fantasies to the analyst. Anna Freud states, "The child is not . . . ready to produce a new edition of its love relationships . . . the old edition is not yet exhausted."[1]

These problems have been raised in one way or another by many analysts. I want to add a seventh, which I believe to be a problem for certain rationalistically oriented therapies—the child's greater responsiveness to feelings. An example of this is seen in infants who cry with certain adults and not

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[1]Freud, Anna, *The Psychoanalytical Treatment of Children*. London: Imago Publishing Co., Ltd., 1946.

with others. The former are usually individuals who carry with them an atmosphere of tension, strangeness, hostility which the child senses, even though other adults do not.

The following discussion of certain aspects of our approach indicates how some of these problems are met and how others do not exist for us.

Similarity of Adult and Child

Many of the above problems are also seen in adults to some degree. One reason they might not be so pronounced is that they may be overshadowed by intellectualizing and sophistication. Take, for example, the acting-out problem. The perfectionistic individual, who must correct every fault when one is revealed, often goes to extremes to change his behavior. One patient who began to see her difficulty in establishing close personal relationships immediately joined a club, got a boy friend and was engaged to marry before another aspect of her neurosis caught her up. Is this different from the ten-year-old boy who discovered a similar lack in himself and promptly announced to his parents that he was going to camp, at the cost of a severe attack of anxiety? Or a younger boy of five who discovered that it was all right to disagree with an adult and began monotonously to challenge all people who held opinions?

With the question of decision and motivation for treatment, one finds that the adult comes into analysis for many reasons which include real suffering and a healthy desire for growth. However, pride—particularly when it is hurt by the failure to accomplish quite unrealistic ends—is a frequent motive for seeking help. It is this in the foreground which at least brings him to the session in which other healthier motivations can be freed for constructive work. In the case of the child, the parent often operates as his pride.

Similarly, the problem of realistic dependency on externals, difficulty in verbal communication and so-called free association are present to some extent in adults. The sensitivity to certain feelings is likewise seen in adult neurotics, who often are very alert to slight changes in the emotional atmosphere, even if these have no connection with them.

I have gone into some detail here not so much to break down the barrier that has been raised, sometimes too rigidly, between children and adults, but, on the contrary, to emphasize one of the positive aspects of our approach: we recognize the essential oneness characteristic of all human nature. At the same time, our respect for the humanness of the individual leads us to the recognition of differentness—the multiplicity of possibilities which exist in every act of the person. We are primarily interested in the particularity of the individual, in his special way of achieving inner unity, the specific value he puts on a trend.

By our interest in the child's point of view, we imply that he, too, has an individual viewpoint. The child, then, is not the repository of raw instincts and the vessel that contains impulses to be curbed, sublimated, socialized. He is not a small edition of a man, nor merely the seedling of later neurosis. He is rather a person, a real one, worthy of all the respect and dignity one human being can offer another. This indicates not merely a concept about human nature, but a spirit of respect for individuality and acceptance of the person as a being in the community of human beings. The neurotic is not only torn and pushed around by his own compulsive trends, he is not only diminished in his own eyes by his self-contempt; but he also actually may be coerced and devalued by his external world. This is particularly true of the child. The spirit of our analytic relationship often brings the first consistent respect for him as a person. For this we must know the individual's values and needs, whether healthy or neurotic, in order to help him nurture the healthy. Therefore nothing is trivial, no observation is meaningless, no interest of the child is without value.

To illustrate: A 15-year-old boy early in analysis started the hour by saying nothing bothered him, but he knew I didn't seem to mind his talking about his interests. He was still a little apologetic as he began to tell about the boxing profession. I learned what he knew of Stillman's Gymnasium, about the "fix" in the fight business, about has-beens and trainers. I began to recognize some aspects of himself on which he might be inter-

ested to work. I remarked that he seemed to be siding with the underdog, but also seemed to be compelled to qualify his condemnation of the authorities to an extent which made it hard to see on which side he really was. This was presented to him as a possibility, acknowledging that here was not a simple bundle of instincts but a complex individual with multiple aspects. This boy, whose behavior toward authority was rebellious, whose real experience with adults contained coercion, and who was virtually paralyzed by threatening inner dictates, at last met interest. More than that, he was enlisted in learning the meaning of himself. His response was to bring further evidence of this tendency in a number of different areas. We had broadened and deepened our mutual experience and raised a valuable area to awareness for further analysis.

Patient-Analyst Relationship

Classical analytic theory and method emphasize the development of a transference neurosis as an essential for analyzing. Anna Freud[2] holds that this is not possible with children, whereas Melanie Klein[3] also within the framework of Freudian theory holds that a transference neurosis does develop in treatment. This imposes upon the analyst the need, as much as possible, to be a *tabula rasa* on which the neurotic projects his unconscious fantasies. We are not interested in the question as to whether the child can or does develop a transference neurosis but in the establishment of the patient-analyst relationship. This is the relationship between two persons engaged in a particular activity. The analyst is interested in helping the patient to realize his self. To accomplish this he must be not a blank page but a whole person, possessed of particular knowledge and willing to use his knowledge and himself for the relationship. This attitude has certain very positive values for the work with children. Because of the acting-out propensities of the child, a factor which represents one aspect of a natural capacity prominently utilized by both healthy and neurotic children, any approach which enjoined inactivity on the analyst would be sorely out of place in a session with a child. Since the original work of Hug-Helmuth[4] and the later elaboration by Melanie Klein and David Levy,[5] play materials have been stock equipment for child analysts—to provide means of expression for the child which would compensate for the verbal handicap to free association.

In Levy's hands they also became tools to facilitate abreactions. We, too, find materials of this kind valuable to gain associative data, but they have another value for the patient-analyst relationship. Thus, not only are blocks, painting equipment, doll figures and furniture used, but games and equipment for carpentry and other handicrafts. And, what is of considerable importance, all these materials are within reach for children of all ages and facility. The significance of the handicraft materials and games for the patient-analyst relation is that the analyst can involve himself when necessary in cooperative or competitive activity. For example, in one session a preadolescent boy suggested we play a game of Jacks. I was not as proficient as he. Nonetheless we played and talked about the game throughout the hour, he the teacher and I the student. The important effect of this for the relationship couldn't be better phrased than in the boy's own words: "You know, most people would be awfully bored when they were in a game they couldn't play so well, but not you." For a boy whose current outstanding difficulty is the problem of establishing personal relationships, the experience in the game and its further interpretations opened a profitable avenue for exploration.

The unwillingness or inability of the child to associate freely has been mentioned. The emphasis has usually been placed on the intellectual, thinking aspect of free association, and the analyst has been chary of becoming a further distraction to the free flow of thought. One of the consequences is to

[2] Freud, Anna, *op. cit.*

[3] Klein, Melanie, *The Psychoanalysis of Children.* London: Hogarth Press, 1949. *Cf.* "Symposium on Child Analysis" in *Contributions to Psychoanalysis, 1921–1945,* London: Hogarth Press, 1948.

[4] Hug-Hellmuth, H., "On the Technique of Child Analysis," *International J. of Psychoanal.,* II, 287, 1921.

[5] Levy, David, "Release Therapy in Young Children," *Psychiatry,* I, 3, 1938.

minimize questions by the analyst, even if a question would clarify a great deal for the patient. Our approach recognizes that the patient is always himself, in the broadest sense, and is always expressing himself. His expression may be verbal or physical, and it is always in relation to someone or something else. Whether the child talks or plays, and whether the analyst sits or participates more actively, a flow of communication of some order always obtains. If the child can be free and frank, what he expresses will be so. If his neurotic trends or those of the analyst impose compliance, or compulsive aggression, this will also be material to be analyzed. It is the analyst's responsibility to minimize his own neurotic remnants in order to allow full expression of the child's needs. The fact that a child starts to play a game with the analyst, then turns to a solitary game at the opposite end of the room, and finally begins to gaze desultorily out of the window provides the same material as though he were on the couch associating to his relationship with his mother, then to a flash thought of a walk alone in the woods, and finally to his indecisiveness about where to go on his vacation.

The so-called educational role of the analyst has been one of the points of difference between Anna Freud and Melanie Klein.[6] According to the former the analyst must play the role of educator in order to keep the child's acting out within bounds. This is necessary because of her belief that the child's own so-called superego controls are weak. Therefore, the analyst as educator must step into this role on occasion. In opposition to this view, Melanie Klein holds that the analyst, as educator, actually interferes with the process of therapy. In criticizing Anna Freud, she says that the former is so interested in maintaining a positive relationship with the child that acting out within the hour is minimized, and the child must let go outside.

Margaret Mahler,[7] an adherent of Anna Freud's views, goes even further in this question of the analyst's role as educator. She states that the analyst himself should not have educational values too different from those of the parents in order to spare the child undue confusion in his identifications.

Educational Role

Our attitude toward this question of the educational role of the analyst resides in our emphasis on the patient-analyst relationship, in our attitude toward moral values, and in our conception of the neurotic character structure. We feel it necessary that the analyst enter the treatment situation with his whole being. Through his own awareness of himself he strives to make available to the patient the healthiest kind of person to be related to. This in no way prevents the child from externalizing to the analyst his own unconscious fantasies. As a person and analyst we have a duty to ourselves and the child to stand for something—consistently but not rigidly. Dr. Ivimey[8] has given explicit recognition to our interest in standing for moral and ethical values and has shown how the neurotic subjugates his values to gain a pseudo-unity. The values we take a stand for are those of being a human being, of being one's real self, creatively related to others. To state succinctly the conception of neurosis out of which this attitude arises, one can cite as a prototype The Devil's Pact. Here the individual, having bartered his soul to the Devil in exchange for glory and spurious living, then tries frantically to retrieve it. In analytic terms the individual's real self is paralyzed or markedly hampered by his pride-invested, conflicting neurotic values. The spirit and method of our approach is then to stand with and for this real self against the Devil. The values of the real self, often unknown or unwanted by the patient, are nonetheless always present. It is part of our methodology to define and support again and again that which is constructive and to indicate the self-destructive forces of the neurotic structure. There is no way of estimating whether our approach results in more or less acting out. However, no premium is placed on the maintenance of a positive relationship as such. The principal interest in the hour is to further the progress

[6] Klein, Melanie, *op. cit.*

[7] Mahler, Margaret, "Child Analysis," in *Modern Trends in Child Psychiatry*, edited by Lewis and Pacella, International Universitiees Press, 1945.

[8] Ivimey, Muriel, "Neurotic Guilt and Healthy Moral Judgment," *Am. J. of Psychoanal.*, IX, 1949.

of the analysis. Here is an example from an hour with a four-year-old boy who in the midst of a quite violent outburst broke a window in the playroom. My attention was not immediately on the window, nor on the equally shattered toy that now lay outside on the street, nor on plans to effect a reconciliation in our relationship. It was on the whole context of the hour, the segment of analytic work that had been going on to that point, and the real situation in the home as I knew it. In my presence, too, was a frightened child waiting for my next move. Would I criticize, blame, tell his mother in the waiting room? Here was the place for knowledge, feeling, action. I commented that there seemed to be something inside him like the boy in school he had told me of and for whom he had some fear. I thought perhaps we'd have to find out more about that. I also, by my manner, showed I was not blaming, nor had I lost interest in him. I was, instead, even more interested and recalled aloud several events of the recent sessions that seemed to be leading up to such an explosion. Maybe even a current upset at home was bothering him, too. I began to clean up some of the glass as I chatted. He began to help. He also added several comments wondering whether the broken toys could be fixed. I replied that everything could be fixed, even mix-ups inside ourselves, if we wanted to work together. The ensuing sessions showed a forward movement in the work, exemplified by more constructive play, a readiness to find his rights and limitations in the relationship, and a significant diminution in his anxiety. In this experience nothing was sacrificed to preserve a relationship—which at best would have been a pseudo-compliant one. Instead the relationship, the verbal interpretations and the activity, were all used to forward the analysis.

Another illustration of the analyst in what might be considered the educational role involves an adolescent girl at an institution to which she had been sent by Children's Court. With a mixture of defiance, fear, and helplessness, she bemoaned the fact that her five runaways in the past month would prolong her commitment. Now, factually, for reasons of group management she had been deprived of some privileges, which would not have been sufficient to curb her. By my decided interest in the girl's motivations, I could indicate to her that realistically life for her at the school could be so much more pleasant if she did not have to break rules. But of far greater moment was the fact that she ran away because she was restless, that something in her made her restless, and that as long as this was so, not running away would be difficult. I added that her stay at the school would not be determined by her runaways, but on our helping her to clear up the restlessness that pushed her. With this, the girl, who had been so defensive and had remained seated at some distance from me, unbuttoned her heavy jacket and pulled her chair closer. Her eyes brightened and softened, she visibly relaxed—and we went further into her quite acute suffering. All through this, a stand was being taken for some values—the child's own self-interest—but no effort was made to use the relationship to get her to conform. Another child, after sensing the destructive aspects in his aggressive behavior, became erratically compliant. At points where assertiveness would have been healthy, he remained in the background. At times when such passivity might have been constructive, he exploded. It is the analyst's duty to define this, to educate the child to reality and to self-interest. Sometimes children confuse assertiveness with aggression, confuse seeing another person's viewpoint with unhealthy compliance. Here again is an educational role, not through coercion and evoking compliance, but through defining reality, taking a stand for growth, analyzing.

Out of the above conception of neurosis arises our attitude towards parents of children in analysis. The neurotic child is constantly involved in this struggle between his real self and his pride system and with the real or externalized obstacles to growth. The struggle is, in a very real sense, for his life. The parents, often neurotic, are also involved in the same struggle. There cannot be in such an approach a place for the attitude, "There are no bad children, only bad parents." With the child and with the parents we take the same stand. We are interested in knowing the child's background, not in order to reduce the differences from our own,

but the better to understand him, his reality and the influences which have acted on him.

We also assume that the parent may bring the child for treatment out of hurt pride, but somewhere in the motivation is also a healthy interest in growth for the child as a person and as a symbol of the parent's own real self. This is the attitude taken by the analyst with the child in order to show the child his own responsibility. This is the attitude with which parents are met directly in order to help make the child's reality even more constructive. To contrast our attitude with that of Melanie Klein,[9] who is interested only that the parent bring the child to the sessions, we feel that for the child, some contact with the parent must be maintained. And for the parent, there is the right to be supported and helped to understand the meaning of some of the acting out which usually accompanies every analysis of a child.

Growth and the Neurotic Process

Our interest in growth, our concept of the real self are of particular value for child analysis. By the real self we mean the growing, creative part of the individual—having an expanding and deepening feeling of the worth of one's self, having oneness with others, yet differences.

The neurotic process involves the real self in a struggle with various aspects of the neurotic character. The pride-invested neurotic values are always being threatened by external reality, by human potentials and traits which are the inner reality and by the contradictions of pseudo-solutions. If the individual has pride invested in generosity, which would require that he meet every demand of others, external reality factually might impose contradictory requests. A tendency to move against people suddenly is confronted by compulsive compliance. The ensuing struggle may produce in the individual anxiety, fear, frustration, depression, rage directed at one's self or others, and some variant of self-contempt. The feelings or reactions may be so isolated from their real basis, appearing in situations whose externals are so different, the person can scarcely avoid assigning them to the situation, or to some abstraction such as his temperament. The resulting feeling of disunity, or discreteness. being at the mercy of imponderables is in itself a source of further neurotic development.

As this neurotic way of living continues, the consequence is further and further alienation from the real self. In its simplest form alienation from self is seen in a person's not recognizing an accomplishment as his own, rather attributing it to luck or others' weakness. In another way, growth may be felt in its negative aspect—i.e. death is nearer.

The real self is available as long as the person lives, but the constant ravages of the neurotic structure pervert its energies more and more. To the extent that he is alienated, the child, as well as the adult neurotic, is deprived of energy with which to fight the neurotic values. Real-self interest becomes less operative as neurotic pride ascends in control.

But there seems to be an advantage which the child has in the more ready availability of the real self. No one is more eager to grow than the child. He constantly looks at adults or older children with envy, and fantasies how things will be in the future. True enough, the neurotic child often is not so interested in the process of growing as he is in being grown. One twelve-year-old boy insisted and firmly believed that his parents had changed his birth certificate, making him three years younger than he believed he was.

But in spite of this, the growth of the child physically and intellectually goes on, even though the neurotic patterns may retard it. The greatest damage is done in his growth toward deep, sincere feelings.

The community offers graded proof of these aspects of growth through the expanding school program and the greater freedom from parental restrictions. Intellectual growth, in reading for example, enables the child to widen his experiences. Ability to calculate and to manage tools adds to his feeling of accomplishment. True, the neurotic child sees neurotic values in these advances. His pride may take these constructive advances and pervert them to nonconstructive ends. But the fact remains, con-

[9] Klein, Melanie, *op. cit.*

structive possibilities are ever and ever opening for the child by virtue of his nature and his culture.

There is another quality which appears to be in the nature of the child—that is his tendency to react as a totality. The young child's rage does not smolder; it bursts into flame. His pleasure is never tempered, but rather goes off in all directions. One rarely hears a laugh from a young child that starts from his lips and stays there. His is a belly laugh. This becomes less so as the child grows older, possibly as a natural consequence which makes other less volatile modes of expression available. But the increased strength of the neurotic structure is also a factor in diminishing spontaneity.

We therefore have with the child a greater degree of feeling and total participation in his reactions, *and* a factual increase of constructive resources. In therapy, there is accordingly a greater possibility to stand with ever-increasing manifestations of the real self against the pride. To illustrate: a young child who formerly took great pleasure in constructing with wood lost interest in this activity as his ambition developed to build intricate and unwieldly projects like a big boy. This required much assistance from adults with tools he couldn't manage. The product at best gave him only a spurious gratification—to say nothing of the ensuing strained relations with the adults from whom he asked assistance. As we worked, as his anxiety lessened, the immediacy of doing a big job diminished. He could be persuaded first to find a tool he could manage, then to feel the value of a less ambitious project. And as he became able to use larger tools and to undertake more intricate jobs, we had within the structure of our mutual experience the direct evidence of satisfying growth. To arrive at this point, he had the use of not only manageable equipment but also materials far beyond his real abilities—although within his imagined capabilities. These provided opportunity to over reach himself, to turn toward me, and provided data for direct interpretation.

The following example illustrates in greater detail the practical working of our interest in the growth process, and the connecting of seemingly disparate experiences. A young boy of 10½ who in his sessions verbalizes a great deal, uses play materials, and moves around considerably came in and, instead of going into the playroom, went into the consultation office, a place he had been to only once—nine months before. Here he sat, then wandered about the room and restlessly scuffed his feet. He was anxious and suddenly complained of stomach cramps.

I commented that he had left the last session in some anger after an expectation was not fulfilled; we had what would have been called an honest difference of opinion between two healthy people. He then spoke of a similar argument that had ensued between himself and a friend. I recalled for him something I had remarked a few weeks ago in his play. He had arranged all the toy figures in couples; it happened that there were pairs for all but two, which were different. These two which were different were promptly engaged in battle to their mutual annihilation. We remembered that this too had occurred on a day he had arrived late because he had had some disagreement with his mother about eating warm or cold cereal. I asked him if he recalled the last time he used this room rather than the playroom. He readily recalled that it was at a time he had expounded vigorously some point of view. He said he was trying to convince me about his opinion of his teacher, although I had not ventured an opinion and he hadn't expressly asked for it. I could then point out the process which emerged from his claim that all people agree with him. There was aggression to the toy figures, detachment from me since the office was far less personal for him than the playroom, psychosomatic symptoms, difficulty in making friends. He was then able to tell me the reason he had been angry with me. As he did so, he relaxed, became less restless, and his stomach cramps disappeared. I could point out the change from nine months ago to the present—emphasizing his ability to express more openly his feelings in relation to me, his interest which enabled him to connect these different things and his sharing with me his feelings of relief.

Here was the connecting *as a process* of a

number of apparently disconnected events. The child gained a greater feeling of unity, a beginning recognition that change goes on in him and in the relationship. As a result he has gained the kind of ground necessary to make himself a factor in his own life.

In the next several sessions this youngster was lackadaisical and depressed. It was possible to add this to the process in terms of his reaction to agreement with me, a blow to his pride in intellect and his ability to know everything. The significance here is that the connectedness of feelings and actions over time and in many relationships injects the notion of unity and change.

This same method is used over small segments; i.e., within the hour—in relation to the therapist, the materials, from one hour to another, from one external event to another, from a point in the past to the present—each time emphasizing the growth, the change, identifying and supporting the constructive—detailing the consequences and ravages of the retarding.

The Problem of Communication

One of the biggest obstacles in the analytic treatment of children is the problem of communication. That is why the problem of motivation for child treatment has loomed so large. Freud[10] was aware of this communication difficulty when he wrote: "The difficulty of feeling one's way into the mental life of a child makes them a particularly difficult piece of work for the physician."

This attitude is a reflection of an important cultural fact: the tendency toward a mechanistic, rationalistic conception of man. One can observe this in many areas of human relations and in the study of human nature. It has given rise to the comparison and at times identification of the child, the primitive, and the psychotic. Certainly there are common features within these three categories, and indeed, with the so-called normal civilized individual. But the grouping has emerged from the difficulties of understanding arising out of a purely intellectualistic, although a sometimes sympathetically tempered, approach. In another direction the similarity with animals has registered, and many study techniques for children and animals are identical. More directly related to therapy is the veritable barrage of psychological tests and mechanical gadgets often applied. While not questioning the validity of such tests, or their applicability and usefulness in certain cases, we can see that their volume and indiscriminate use represents a confession of failure to get to the child. One adolescent boy who placed a high value on intellect and who was quite detached once said that I was a fool to try to understand his dreams because he had to translate them into words which I had to retranslate into meanings of my own. He ended with: "There ought to be a machine."

It is not infrequent to hear it said of a father that he was not interested in his child until he could talk, or even beyond that, till his youngster could carry on an intelligent conversation. One might say, too, that in such a situation, the child probably would develop little interest in such a parent. Here is an attitude which places little value on the person and a high value on the function.

For many reasons, communication between children and adults may be difficult. It is extremely difficult to carry on a very effective relationship from a distance; but the adult whose own equilibrium is precarious will find a real threat in closeness to the often volatile, acting-out child. This is also seen in the so-called "feeling type" individual. He takes pride in his sensitivity but must maintain distance in order to avoid hurt pride.

Now what does this mean for the child analyst? Here he is confronted with an individual, neurotic or not, whose communication system is not primarily verbal or conceptual but is rather one of a feeling and physical expressiveness. What verbalizing there is is often limited to the immediate situation. The wealth of so-called material, such as recollections from the past, the troubles in the office or at home, are lacking. Even with more verbose adolescents there is often a considerable lack of attention to this kind of data. In addition, to the extent the child is neurotic, to that extent will relatedness be more difficult. It is not merely

[10] Freud, S., "The History of an Infantile Neurosis," *Collected Papers* III, International Psychoanalytical Library, 9, 1925.

that the vocabulary is different—this can be learned, although it can hardly in that case be spontaneous. But what might be the consequences for therapy if the analyst relies entirely on this verbal mode of communication?

To make this clearer, I refer again to our understanding of the real self. It is the dynamic synthesis of our necessity and our possibility, it is our nature which is at once being and becoming. As we are our real selves, we are creative, of things, *of human relationships.* When we are one with our own middle, our resources, our intellect, our strength, our accomplishments are ours—owned by us, delighted in by us, esteemed by us. As we are ourselves, we can feel our earth-boundness and our heaven-aspiring and can live creatively. Our immediate interest here is in the interpersonal relationship aspects of the real self—in the communication between human beings. When two human beings are their real selves, their relationship is mutual, their intellect is in the service of the relationship, whether, to use Macmurray's terms, the relationship be personal or functional. Their strength and their wisdom are for the relationship. They enter the relationship with their whole selves, with their feeling of themselves and the other. This is the meaning of the human relationship. This is the goal of analysis, a part of which is the recognition that continual self analysis is essential. And why should this not be so when we recognize the real self as the relationship between limits and limitlessness, and one of these limits is time.

What situation then obtains between two people, one of whom is closer to his real self and one of whom is neurotic, to a greater or lesser degree alienated from his self? The former will first recognize in the other another human being. He will respect and esteem him as a person. He will feel the struggle of the other's self against the tyranny of the neurotic structure, or he will sense the apathy and the hopelessness. With his eyes, his ears, his intellect, all in the service of his own self, he will delineate the various manifestations of the constructive and the destructive in the other. He will relate to and respect the neurotic part of the other, feeling its power and knowing it to be the enemy. A healthy person and a less healthy one may have a relationship which approximates a personal one, i.e., one that has no purpose beyond itself. However, the further removed the neurotic is from himself, the less wholehearted can be the relationship. The neurotic enters the relationship as a person, but as a person divided and involved in a struggle between his real self and his neurotic pride. From his side he relates in whatever way he can. In so far as he can make contact, this is constructive. But his neurotic pride in most instances dictates the character of the contact. Consider, for example, the patient-analyst relationship. The patient, who may have considerable pride in being able to solve his own problems, finds himself in the position of seeking help. His reaction to this may range from haughty arrogance to abject self-contempt. He may humbly comply with every one of the analyst's interpretations or vindictively fight them. With children, from a variety of motives, the analyst may be confronted with assaultiveness, rank indifference to him and preoccupation with toys, unctuous politeness, elusiveness, marked dependency and clinging. The analyst must be able, with his whole self, to feel the real self through the neurotic character, the struggle of the child, and with his special analytic knowledge as well as his ingenuity work to support and strengthen the health in the child.

What is the situation if the analyst is himself alienated to some degree? The relationship then will have added to it his own neurotic needs. He will be forced more and more to use auxiliary tools, and these will be less in the service of his real self and more in the service of his pride. Let us take the analyst who must rely heavily on his intellect and on keen observation through his special senses. Along with this, one usually finds a high degree of detachment, and whatever feeling possibilities exist are at a distance. First, the child, finding contact so hard to establish can hardly be blamed if he looks askance at the sessions, becomes interested only in play, and ultimately in not coming to the hour. And for the therapist, no matter how intense his wish to help, he cannot keep from utter boredom, frustration or hopelessness—a feeling which gets across to the child

with the expected negative consequences.

There is a tendency in such situations to fall back on other devices, and here the battery of psychological tests comes in. Another consequence bears heavily on the nature and timing of interpretations. For example, the child elects to paint in his hour and the analyst keenly and silently observes. Here are several of the possible observations that could be made: The child is occupied in a lone activity; he is carefully applying the paint rather than smearing it; he seems to prefer blue and red colors; there are no people in it; the work shows quite some talent; the layout is symmetrical, and so on. It is true that all these observations mean something, individually and collectively. But what to do with them? Shall the constructive aspect be commented on, the detachment, the need for control? Shall the fact that he uses blue and red today rather than his usual blue and green combination be questioned? It would take some intellectual gymnastics to arrive at a decision, and the value of the interpretation to the progress of the analysis becomes a matter close to chance. On the other hand, if the analyst has a feeling for the process of the analysis, for the status of the child before him, then his knowledge and his observations have a far greater likelihood of reaching the child and forwarding the analysis. Or if the analyst himself puts a high value on verbal communication, he is apt, with the intellectually precocious youngster, to delude himself into the belief that he is making an excellent contact. But he is hardly working at any depth.

Without the ability to communicate with the child, to relate to him as a human being the spirit of our approach, the patient-analyst relation, the attitude toward parents, the understanding of the neurotic process and growth become mere words or empty gestures. Then all the limitations to the treatment of children become almost insurmountable obstacles.

Summary

This paper has stressed the oneness and the differentness of individuals. I have indicated also that there is much in the analysis of children which is similar to that of adults. Some of the differences which obtain in greater measure with children have been mentioned but much further work remains to be done in this area.

Some aspects of the therapist have been presented, but here, too, more detailed investigations as to specific qualities and talents must be made. The fact of the matter is that there are relatively few child analysts today, despite a great need for them in therapy, education and child-guidance work. While a multitude of factors, personal and cultural, are involved, the outstanding problem we can lessen is that which relates to the retarding force of alienation from one's real self. To the extent that our training of analysts and our therapy of workers with children reduces this, to that extent will we make a significant contribution to child analysis.

MEDICAL PROBLEMS IN PSYCHOANALYSIS

I. THE INTERNIST'S VIEWPOINT

GARY ZUCKER *

IN RECENT years the number of patients who have entered analysis has increased tremendously. The medical profession as well as the laity has become more aware of psychosomatic mechanisms in disease and their treatment by psychoanalysis. Yet it appears that a majority of patients start psychoanalysis on their own initiative, while the minority have been referred by their doctors. These patients may have organic illnesses which precede the analysis or which occur during it.

The purpose of this presentation is to discuss some of the special aspects of practising medicine with patients who are undergoing psychoanalysis and to point out how the internist can help both patient and analyst.

The aim of the internist, regardless of the type of patient, should be to collect enough facts from the history and examination to make as complete and as accurate a diagnosis as possible and to prescribe the proper medical therapy. Because of certain special problems and attitudes, however, the internist has to be most discriminating in his approach to the patient in analysis. It is necessary for him to be generally sympathetic toward the idea of psychoanalysis and genuinely interested in people and their problems. That does not mean that the internist should act like an analyst. As a matter of fact, he would do well to avoid using any of the techniques or interpretations of psychoanalysis. There are dangers to him, to the patient and the analyst if he does not exercise caution. The danger to himself arises in becoming too interested in the emotional mechanisms of the patient's neurosis and not enough in ferreting out true organic illnesses from the maze of functional symptoms. The patient may suffer from the internist's allowing him to feel that another doctor is doing what the analyst should rightfully do. Too, if the internist allows it, the patient may play him against the analyst in very subtle ways. There are also patients who resent the internist's questioning them about their emotional conflicts. To arouse this resentment is to alienate the patient from the doctor and his services. Finally, the danger to the analyst arises from interfering with his work and from advising him improperly as to the physical condition of the patient.

THE PATIENT-INTERNIST RELATIONSHIP

The relationship between the internist and the patient in analysis is influenced not only by what the patient thinks of doctors but also by what the internist thinks of the patient. The attitude of patients is condi-

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tioned by their previous contacts with doctors. In many cases these have not been happy ones. They have been called hypochondriacs, neurotics, worriers or just nervous people. Often these hasty diagnoses have been made without benefit of complete physical examinations. It is small wonder, then, that such patients suspect most internists of being hostile to psychoanalysis and dislike going to their offices for fear of being criticized. Even if assured of sympathetic treatment, they go with misgivings and doubt. On the other hand, one encounters patients who are so convinced of the neurotic nature of their complaints that they are apologetic when they find themselves in the office of an internist. They hate to waste the doctor's time. In between these extremes there are many patients who, while recognizing their own neurosis, nevertheless look to the internist for his advice and reassurance about their physical health. For his part, the first responsibility of the internist is to evaluate the personality of the new patient and to act accordingly. This is often a difficult task, considering the limited amount of information that the internist has about the patient during the first visit. Most often, the internist must depend on his intuitive judgment of people. He may be right most of the time, but he may be wrong on many occasions. Here the analyst can be of considerable help. It is the practice of analysts not to call to make appointments for their patients. For this, there are understandable reasons. That does not mean, however, that analysts should not inform the internist of the general problem or personality make-up of each patient. With such information, the internist is less apt to blunder and thereby alienate his patient. This is particularly true if the patient is known to have a marked hostility towards medical doctors. But while such information may be helpful, it is not always necessary. The internist will recognize a severely depressed patient and he will utilize a cautious and unexcited approach. He will also recognize the apathetic patient and recognize the need for complete neutrality in his actions.

A good medical history is the foundation of accurate medical diagnosis, particularly when dealing with the neurotic individual. A painstaking, discriminating history will often help distinguish between neurotic symptoms and suspicious symptoms of organic disease. To accomplish this end, the doctor must be sympathetic, patient and a good listener. He must beware of acting critical, surprised or amused at anything the patient may tell him. It is equally important not to interrupt the patient until he has had his first say. Careful observation of the patient during the recital of his own history will give further clues to his personality. The first part of the history is often given quite rapidly, especially since many come prepared with a list of notes. But when the patient has finished producing his own complaints, the doctor must proceed to question the patient systematically. This is important because patients often will not mention very obvious symptoms of illnesses. If undertaken tactfully, this question-and-answer period usually produces much information of the type the internist needs to arrive at a diagnosis. Following this, the patient is ready for a complete examination.

This should include a rectal examination in every male and a pelvic examination in every female. A routine blood count, Wasserman test, urine analysis, sedimentation rate and chest X-ray are necessary. An electrocardiogram or any other special test or X-ray examination should be done on indication. During the course of the physical examination, the internist should proceed with definiteness and certainty but in an unhurried manner. He should not only inspect but also palpate every area where the patient has localized a complaint. It is best not to be too silent or serious during this part of the consultation. To allay the fears of an anxious patient, brief explanations should be made as to what is being done and why.

Many problems arise during the examination that require special handling. It is well not to overexpose the unduly modest patient. The patient should also be prepared in advance for any instrumentation, examination in the dark room or examination of the genital organs. In the latter case, this should be carried out with proper regard for the feelings and attitude of the patient in this sphere. Perhaps in no other part of the body is an awareness of the problems of the neurotic more important. An abrupt and

painful examination can be very disturbing to the patient. One analyst told the story of a female patient whom he had referred directly to a gynecologist. This woman was so pained and upset by his manner and his examination that it took the analyst four sessions to help her recuperate. Male patients have had similar experiences with urologists. It is not unfair to say that some surgeons do not concern themselves with the emotional problems of the patient. For that reason, the internist with an understanding of the problems of the neurotic should be consulted first about any illness. It should be his responsibility to refer the patient for any further specialist care. It goes without saying that he will brief the secondary specialist concerning the patient's problems and also select a doctor who will be understanding and thorough.

Once the internist has completed the examination, he should attempt to formulate his diagnosis at once. To send the patient away with instructions to return at a subsequent date for a final diagnosis is to provoke further anxieties. The doctor should strive to give his diagnosis in simple and understandable terms. As far as possible, he should offer a reasonable explanation for each complaint. If no organic disease is found, he should notify the patient in no uncertain terms. Patients in analysis appreciate the reassurance of being given a clean bill of health. The internist should also encourage such patients to continue their analysis. When organic disease is found, a fair evaluation of it is called for. The doctor should neither alarm the patient with premature speculations nor exaggerate the seriousness of the illness, nor should he mislead the patient by minimizing its importance. Honest reassurance is possible in every case. Naïve and untruthful reassurance will eventually undermine the confidence of the patient in the physician. Here, too, prior discussion with the analyst will help the internist manage the patient with greater success.

The next task of the internist is to outline the treatment and to make clear the goal expected. As a general rule, the patient in analysis may be given the same medicines as any other patient. However, alcohol should not be advised for an alcoholic in remission nor narcotics for an ex-addict. It is good practice to prescribe only small quantities of sedatives—and then only with the knowledge and approval of the analyst. Since so many analysts hesitate to prescribe sedatives, they can best serve their patients' interests by notifying internists of their desires.

Finally, the consultation is not complete until the internist has notified the patient that a full report of his findings and recommendations will go to the analyst. This report can be of considerable importance. In many cases, it will be the first complete medical history of the patient. In others, it will contain information of organic disease not previously brought up in any of the analytic interviews. In all cases, it will help the analyst decide which of the symptoms are organic and which are neurotic and when the patient may need further medical examination.

Several years of experience with patients in analysis have served to emphasize that there are numerous indications for seeking the help of the internist and that proper medical treatment can relieve distressing symptoms and aid the progress of the analysis. These conclusions can best be understood by discussing in more detail the various types of medical problems encountered.

1. Unexamined Patients

Among unexamined patients are included patients who have never been examined, not recently examined, or only incompletely examined in the past. This group needs special attention by the analyst. The symptoms may add up to a diagnosis of neurosis, but in the absence of any recent or adequate examination, the analyst cannot be sure that neurosis is the *only* diagnosis. Very often the diagnosis of neurosis is made only after exclusion of organic disease. This differential diagnosis is often not possible even after the most careful medical history. Thorough physical examination is necessary. The analyst is not equipped physically or by experience to do this type of investigation, especially now that doctors with only one-year clinical interneships are going directly into the study of psychoanalysis as a specialty. The danger of submitting a patient to analysis who has never been examined or exam-

ined inadequately is quite apparent and requires strong emphasis. Organic disease of various types can mimic a neurosis. Brain tumor, neurosyphilis, amebiasis, hyperthyroidism, hypothyroidism, tuberculosis, pituitary insufficiency, kidney disease and heart disease can do it, to name just a few. How frequently an organic disease is psychoanalyzed, I cannot state. If the analyst will constantly ask himself, "Is the patient physically sick?", such mistakes will be rare. I have personally encountered only one case of a patient's being analyzed for an undiagnosed organic disease. This was a forty-year-old man who complained of pressing substernal pain, usually brought on by effort. He had a family history of both parents, two brothers, and one sister dying of heart disease between thirty-five and fifty. His complaint started shortly after the death of his sister. He was an extremely anxious person and had a fear of dying of heart disease. An examination done more than one year prior to his analysis was said to have shown a normal heart and electrocardiogram. He was told that the pain was functional and was advised to disregard it and to make as much effort as he wanted. The doctor reassured him that once he overcame his fear, the pain would disappear. He underwent psychoanalysis as the means of ridding himself of his fear and pain. After one year of analysis, the pain grew worse and he could not walk more than one block without experiencing pain. This aggravation coincided with a crisis in his analysis, and the patient was satisfied to attribute it to that. However, the analyst was not happy about the aggravation of the pain and wisely suggested reexamination. The entire examination, including X-ray of the chest and electrocardiogram, was normal; but the suspicion of organic cardiac disease was so great that an electrocardiogram was done after exercise—revealing definite changes diagnostic of coronary artery disease. The patient was actually suffering from angina pectoris. Furthermore, the tensions resulting from the disclosure of deep-seated emotional conflicts was at that time increasing his pain by adding spasm to the already narrowed coronary circulation. This case illustrates how the failure to employ every method of medical investigation of the heart led to an erroneous diagnosis, to the harmful prescription of unlimited activity and to the limited success of analysis. It also emphasizes the need for the analyst to be constantly alerted to the possibility of organic disease. Since this patient has accepted the condition for what it is, and since he has restricted his activities and taken vasodilators, he has suffered much less pain.

Not all patients who come to the analyst without a doctor or after an inadequate examination need have any organic disease. Some may be entirely healthy, in which case it is reassuring to both patient and analyst to know that.

2. Unknown Illness

A patient may have an illness unknown to the analyst or to both analyst and patient. Some of these diseases may be active and entirely asymptomatic; but they may subsequently be aggravated by the emotional upheaval experienced in analysis. The analyst, knowing this to be so, would either postpone analysis or proceed with more caution than usual. I should like to cite one such case with pulmonary tuberculosis. This was a thirty-eight-year-old male who had been in analysis for about two years before my first examination. Five years previously, he had had a spot in his right upper lobe that was suspected of being a virus pneumonia or tuberculosis. It cleared without restriction of his physical activity. He went into his analysis without any further medical investigation. For several months, his marital maladjustment had created quite an emotional turmoil. He started to cough and lose weight. Examination revealed a fresh, exudative, pulmonary tuberculosis with cavity formation in the right upper lobe and a positive sputum. Emotional tensions have long been known to produce exacerbations in pulmonary tuberculosis. Since pulmonary tuberculosis may exist in active form and yet be asymptomatic, a routine chest X-ray would seem to be a desirable precaution in every patient in analysis. A similar connection between emotional tensions and other diseases is known to exist—for example, diabetes, hyperthyroidism, high blood pressure and epilepsy. All these are diagnosable by a thorough history and examination, yet all

may be unknown at the time to both patient and analyst.

3. Complicating Illness

A patient may develop an acute illness during analysis. The symptoms are usually obvious to both patient and analyst. The indication for a referral to an internist is clear. Treatment of the acute ailment is not the only outcome of this visit. Other conditions may be discovered even more important than the presenting complaint. If nothing else is found, the treatment of the acute illness gives an excellent opportunity for the internist to develop a rapport with the patient which may be of future value.

4. Attempted Suicide

If a patient attempts to poison himself, the analyst will be anxious to enlist the services of the internist. The situation calls for immediate attention and the prompt institution of treatment. Vigorous measures must be used to remove as much of the drug as possible, to detoxify what cannot be removed and to give supportive treatment in the form of fluids, oxygen and stimulants. If the patient is comatose, hospitalization is usually desirable, since many specialized procedures can be more easily carried out in the hospital. However, if the patient is only stuporous, he may present many compelling reasons for staying at home. Should home conditions be suitable and adequate nursing help available, such a patient may successfully be treated at home. This is mostly so when a moderate dose of sleeping pills or some caustic substance has been ingested. However, the absence of coma is not always a reliable sign of the severity of the poisoning. For example, mercury bichloride may produce insidious but critical damage to the kidneys in a conscious patient. To procrastinate with such a patient at home is to run the risk of permanent or fatal kidney damage. Nowadays the remarkable antidotal action of BAL and the availability of the artificial kidney and peritoneal lavage make it imperative that mercury poisoning be diagnosed and treated without delay at a hospital. The same can be said for arsenic and other heavy-metal poisonings.

Besides the complexity of the management of self-poisonings, there are many medical complications which may arise during their course. Any analyst who has undertaken the treatment of an attempted suicide will agree that it is a job best left to the internist. There is a practical point involved here, too. The patient may be restored to good health and dislike the internist for it. The analyst, by remaining out of the picture, may continue in a favorable position to resume the analysis.

5. Alcoholics

Alcoholics when intoxicated are neither amenable to analysis nor attentive to their own nutrition. Avitaminosis and increased susceptibility to infection often result. Such patients should regularly be examined during an alcoholic spree, if possible, but most certainly after it is over. It may not be possible to induce the patient to stop drinking, but the internist may prevail upon him to improve his diet by taking large doses of vitamins orally and by injection to prevent damage to the liver and to the nervous system. If the patient is seen only after the alcoholic episode is over, a thorough examination for signs of infection, avitaminosis, neuritis, liver disease, anemia and malnutrition is indicated. I have had occasion to find dental, pulmonary and urinary-tract infections complicate and prolong a bout of alcoholism. In each case, alcohol was being taken to relieve the pain and distress of the infection. In each case, alleviation of the infection coincided with the cessation of high alcohol intake.

One of the chief responsibilities of the internist to the alcoholic patient is to educate him about the nutritional requirements of the body during and after the alcoholic episode. One cannot always be successful with this approach, but I recall two cases who regularly appeared for vitamin injections whenever they felt they had had too much. Relatives of patients have said that the alcoholic should not be informed about the value of an additional vitamin intake. On the one hand, it has been said that the alcoholism would be encouraged if the patient knew the vitamins would prevent organic damage. On the other hand, some have said the patient would then purposely avoid vitamins in order to inflict injury upon

himself. The internist has no place in this futile dilemma. His responsibility to all patients in analysis is to prescribe proper medical therapy. Since the patient is already in the hands of the analyst, the solution of all such dilemmas can best be found there.

6. Hypochondriacs

Hypochondriacal patients are most difficult to manage. They are a problem to the analyst and the internist and a threat to themselves. Each symptom or anxiety may be satisfactorily explained away, only to be replaced by another. After a few such experiences, it becomes difficult to be completely patient or objective. Yet the internist and the analyst must be eternally vigilant. For the internist, there is almost no limit to the thoroughness of the examination necessary to assure himself that organic disease is not present. And when he is finally certain that the complaint is functional in origin, the hypochondriac plagues him with the question, "Are you sure?" Every once in a while, a real disease develops. Overlooking it can have serious consequences to the patient. I recently saw a patient, a young woman of 45, who had a history of various types of abdominal pain for over twenty years. During that time she had had, first, an exploratory laparotomy with no disease found, then an appendectomy for a normal appendix and finally a hysterectomy for an inconsequential fibroid uterus. In each case the operation was done because the patient tormented the doctors with complaints of pain and persecuted them by asking if they were sure nothing serious was escaping their attention. At other times, her complaints consisted of pains in the head, palpitations, pains over the heart, diarrhea, rectal pain and many others. Each time, extensive examinations were carried out in various offices, consultation clinics and hospitals, and in every case a diagnosis of neurosis was made. Her most recent illness was a severe attack of upper abdominal pain, similar to but not the same as many others in the past. This time, however, the findings—including the X-rays of the gall bladder—indicated an acute cholecystitis with stones in the gall bladder. Here at last was a condition that was organic and required surgical treatment.

7. Postponement of Treatment

A patient may have an organic disease which the internist chooses not to treat because of the possible effect of such treatment on the basic neurotic personality. I can best illustrate this point by citing a few cases. The first was a 42-year-old woman who had increased and painful menstruation due to menopausal changes and a small fibroid. The patient was referred to a gynecologist who confirmed the diagnosis. He failed to find any cancer cells in the cervical smear. He advised hysterectomy or X-ray therapy to the ovaries to produce an artificial menopause. The patient refused operation. X-ray therapy was withheld for fear that it might bring on an abrupt menopause and aggravate the neurotic symptoms which were quite intense at the time.

The second case was a 55-year-old woman suffering from a moderate obesity and hypothyroidism. Her basal-metabolic rate was minus twenty-five percent. In the past, treatment with thyroid had produced agitation and anxiety. The patient felt most placid and relaxed whenever the basal-metabolic rate was low. In addition, any attempt to make her adhere to a strict diet evoked anxiety and hostility. Weighing all these factors, it was considered advisable not to interfere with this patient's hypothyroidism or obesity.

Whenever organic disease threatens the life of the patient, of course, the internist should never procrastinate with treatment.

8. Palliation of Psychosomatic Disease

This and the subsequent groups require special emphasis and closer cooperation between the internist and analyst. There are a number of diseases which are now generally considered to be psychogenic—either entirely or almost so. These include peptic ulcer, hypertension, hay fever, asthma, hives, vasomotor rhinitis, migraine and Raynaud's disease, among others. It is also well established that in many cases psychoanalysis alone can cure or relieve the illness *in the long run*. However, it is equally well known that at any given moment during analysis, should an exacerbation of the disease occur, the attack can be stopped or ameliorated by

medical treatment. It is also well to bear in mind that, in addition to emotional stresses, certain physical or chemical factors may play a contributory part in psychosomatic illness. The proper emphasis on both the medical treatment and the analytic approach is necessary in order to make the patient comfortable, prevent possible complications and allow the patient to continue with the analysis. Two cases will best illustrate the problem of the use of palliative medical treatment for psychosomatic illnesses during analysis.

Case 1. A 50-year-old woman had had high blood pressure for only a few years. During two years of analysis there had been practically no change in the blood pressure. It varied from 160/100 to 230/120. However, in some patients a rigid restriction of salt in the diet can ameliorate hypertension, and this patient agreed to stay on such a diet. The change in the blood pressure was impressive. It came down to a low of 132/84 and has never since been above 156/98. Concurrently, there was improvement in the general condition and an increase in the capacity of the patient to work and a decrease in the fear of complications. Interestingly enough, with the disappearance of the severe hypertension, another psychosomatic illness appeared—vasomotor rhinitis. Here, too, medical treatment in the form of an anti-histaminic gave the patient sufficient comfort to allow her to continue with her work and analysis.

Case 2. This case illustrates a psychosomatic disease with an acute exacerbation for which the analyst did not find it reasonable to suggest medical treatment. This was a 42-year-old man who was suffering from bronchial asthma for one month. The asthma developed during the ninth month of his analysis. It was severe enough to interfere with the analytic session. The analyst emphasized that asthma was a psychosomatic disease. However, since the patient was unable to make any progress in analysis with his asthma, the analysis was temporarily discontinued with the consent of the analyst. Two weeks later the patient, on his own, sought medical treatment and obtained relief from his asthma. One wonders whether it might not have been better for the patient if the analyst had suggested medical treatment sooner.

9. Aggravation of Organic Disease

A patient may have an underlying organic disease which is periodically aggravated by psychogenic causes. These are not truly psychosomatic illnesses. Here, as in the previous group, proper medical treatment can keep the patient in good health and permit better progress in analysis. Such diseases include epilepsy, pulmonary tuberculosis and cardiac irregularities. I can cite the case of a young woman who, prior to analysis, had had several indefinite attacks of unconsciousness. During analysis, these increased in frequency and severity. A diagnosis of idiopathic epilepsy was made and proved by the electroencephalogram. The use of some of the newer anti-convulsant drugs controlled the convulsive tendencies sufficiently to allow her to make more progress in analysis. In contrast to this case is one who also suffered from epilepsy. This patient had been successfully treated with dilantin for several years without having any further attacks. For various reasons she decided to undertake analysis. Her analyst believed epilepsy to be completely a psychogenic disease and advised her to discontinue taking dilantin. She promptly developed attacks of epilepsy which not only interfered with her analysis but prejudiced her against continuing.

There are numerous cardiac irregularities which may be precipitated by psychogenic influences. These can be quite frightening to the patient, yet often the patient will assume that since there have been adequate emotional causes the attack of palpitation is entirely psychosomatic. Careful examination, including an electrocardiogram, may reveal in such cases an underlying condition which can be specifically treated in order to prevent recurrences.

10. Progress of Disease

A patient may require an internist's evaluation of the effect of analysis upon a psychosomatic illness. From the enumeration of the various types of psychosomatic illnesses, it is apparent that the analyst is not equipped physically or by experience to make an adequate examination of such patients. The role

of the internist and his relationship to these patients are quite obvious and need no further discussion.

11. Organic Masquerading As Functional

Many patients have organic diseases that masquerade as psychosomatic ailments. This does not mean that the patient is being analyzed for an organic disease, but rather that new symptoms appear which the patient or analyst or both may consider to be of functional origin. However, whenever new symptoms develop during an analysis which do not quite fit into the analytic situation, a medical examination would seem to be indicated. The following case is quite unusual and instructive. This was a young man who had been under analysis for two years. There was much that was still unsettled in his personal, family and business life. He presented himself with the complaint of excruciating, throbbing headaches associated with nausea and vomiting. These headaches were of the migraine type. Of special interest was the fact that the headaches appeared while he was at work and disappeared when he went home and on week ends. It is quite typical for migraine to develop in emotionally tense individuals when they are confronted with their responsibilities at work. In this case, the patient felt there were enough reasons for his having headaches. However, the patient seemed to be quite happy at his job, and there was a suspicion that there might be a noxious agent in the atmosphere in his shop causing his headaches. He was instructed to return to work and to find out if there were any such fumes and to inquire if any other worker was similarly affected. It was discovered that a gas heater was leaking beside him and that he and another worker were being poisoned by carbon-monoxide fumes. Carbon-monoxide poisoning produces headaches indistinguishable from migraine. The headaches disappeared when the gas leak was repaired. I cite this case as a striking example of how the internist can aid the analyst in differentiating organic disease from neurotic complaints.

Summary

The purpose of this paper has been to present the internist's point of view of his own relationship to patients in analysis and to illustrate the numerous occasions when medical diagnosis and treatment are required during analysis. A closer integration between the work of the internist and analyst is imperative since so many patients undertake analysis on their own initiative without a recent or a complete medical investigation. Many neurotics avoid medical examination either because of previous disagreeable experiences with doctors or because they believe all their symptoms to be neurotic in nature. The internist can help overcome these barriers if he is aware of the neurotic patient's problems, if he is sympathetic to psychoanalysis, if he is thorough and objective in his examination, complete in his diagnosis and treatment and reassuring in his manner. The analyst's responsibility consists of being constantly aware of the possibility that old or new symptoms may be organic in origin. By this dual interest and approach to the patient in analysis, the internist is able to contribute to the relief of the patient and to better progress in the analysis. The danger of overlooking organic disease will also be minimized.

Proper medical diagnosis and treatment are of particular help when confronted with the following problems:

1. The patient who has never been examined, not recently examined or only incompletely examined in the past.
2. The patient who has an illness unknown to himself or to the analyst or both.
3. A complicating illness which develops during analysis.
4. Attempted suicide.
5. The alcoholic patient.
6. Hypochondriasis which obscures organic disease.
7. A neurosis which requires that treatment of an organic disease be postponed.
8. A psychosomatic disease which requires palliation.
9. A known organic disease which may be aggravated by emotional tensions.
10. The evaluation of the effect of analysis on a psychosomatic disease.
11. Organic disease which masquerades as a neurosis.

MEDICAL PROBLEMS IN PSYCHOANALYSIS

II. THE PSYCHOANALYST'S VIEWPOINT

HAROLD KELMAN*

MEDICAL problems do arise during psychoanalytic therapy. Patients bring them with them or the problems become apparent during a therapy—which may extend over a period of four or more years. For a number of reasons, a restatement of the analyst's role concerning medical problems seems essential at this time.

A RESTATEMENT

There has been a considerable increase in the numbers of persons receiving analytic help. Medical men are more frequently referring their patients to analysts, but most of the increase is due to individuals contacting analysts on their own initiative. Many do not have a family physician, have not been physically examined in a long time or may be antipathetic to medical men for various reasons. They may have had some unpleasant experience due to actual or imagined medical mismanagement. They in fact may have been over-, under- or erroneously treated for a physical disorder, subsequently diagnosed and adequately treated by another internist. Or their analytic therapy may have been delayed by their physician's lack of knowledge of analysis or bias against it. Such instances are diminishing.

HISTORICAL SURVEY

Other changes make this redefinition necessary. Prior to World War II, most psychiatrists who subsequently became analysts had a long background in the practice of medicine and hence more immediately concerned themselves with medical problems. Others had practiced psychiatry in institutions where it was their daily duty to care for their patients' medical needs. Medical consciousness—a spontaneous thinking in terms of the maintenance of physical health and the treatment of physical disease—became an embedded part of their functioning as therapists.

More recently, psychiatrists are beginning their post-graduate training in psychoanalysis much earlier in their medical careers. One reason is the significant position psychoanalysis has attained in the medical world and in the mind of the public. Also, service in the armed forces made for some physicians the break with their previous medical life. Once uprooted, they could more objectively review their futures. Some rediscovered an old desire to become psychiatrist. For others, it was an opportunity to get the training in psychiatry for which they had been waiting. For still others a new field of interest had

Elaboration of a discussion of the paper "Medical Problems in Psychoanalysis—I. The Internist's Viewpoint," by Gary Zucker, M.D. See page 48.

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been stimulated. In this latter group were those who had gone directly from internships into the armed forces and who were, for the first time, deciding which direction their medical future would take. On discharge they could obtain the necessary psychiatric training among the many programs arranged for just such men. Help through the G.I. Bill of Rights and various veterans' programs was a further stimulus. This sudden increase of interest in post-graduate training in psychoanalysis had its advantages but often did not allow for an orderly process of maturation, in time and depth, before arriving at such a significant decision.

Some doctors have had the additional disadvantage of a three- instead of a four-year medical course, and a nine months medical internship instead of the usual minimum of a full year. Likewise most of their psychiatric training they received while in the armed forces. As a result the duration of their training was shorter than usual; and the atmosphere in which they received it was not as conducive to the actual learning of medicine and psychiatry and of both's becoming an integral part of their therapeutic outlook. In short, they did not receive as thorough a medical orientation as would be necessary for them to develop a true medical consciousness. Even with analysts who have had a longer background in medicine there is a tendency for their medical awareness to dim—though less so.

Factors in Analytic Practice

This tendency is furthered by the nature of psychoanalytic therapy and the way most of it is practiced today. The majority of analysts devote themselves exclusively to private practice. Since an analyst sees only one patient at a time and alone—only a few in a full day's practice and not very many even in a number of years of practice—he cannot derive the benefits to be obtained from a number of colleagues' seeing the same patient at the same time. Also the values that derive from seeing greater numbers of patients—variety and for comparisons—are much reduced. This tendency is furthered by specialization, which leads to an over-focusing on one aspect of an individual's problems at the expense of losing sight of others. The analyst, concerned as he should be with his patient's emotional difficulties, may allow the physical aspects of the whole person to slip from his awareness. This trend away from the organic I have observed in psychiatrists during the course of their analytic training. This swing toward an over-focus on the functional is less extreme with those who are better grounded in medicine. In time a more mature viewpoint is reached with a truer feeling for the whole person. But this does not always take place to an adequate degree.

The nature of analytic therapy tends to discourage the seeking of another colleague's opinion—particularly in an area where the above factors already have caused his alertness to diminish. The analyst, alone with one patient at a time, has to operate on his own almost all the time and is limited in the checks on his technique except those he may seek out. Except where a patient is referred by a physician with an accompanying report or by a colleague who gives a short résumé of his findings, each analyst collects all the information he gets. He naturally begins to operate in terms of self-sufficiency. His position with reference to his patients, their needs, and his own unresolved problems further encourage attitudes of self-sufficiency or omnipotence. Against such possibilities there are safeguards. There is, of course, the personal analysis of the psychiatrist as well as the supervision he receives while treating patients during his training period. Experience has shown that personal analysis and supervised analytic work have not been adequate safeguards against a narrowing viewpoint. What is essential is a theory of human motivation which stimulates and satisfies a spirit of self-investigation and encourages productive work in extending psychoanalytic knowledge. An analyst who continues self-analysis, consults with a colleague about his findings, and in addition seeks formal analytic help from time to time will not become limited in viewpoint. Continued participation in the advancement of psychoanalysis is the other safeguard. This can be through participation in teaching, writing, discussion groups, lectures and courses.

To the above discouragement to seeking

help from another may be added an aversion resulting from unpleasant experiences with internists. A number of an analyst's patients may have had factual bad encounters with medical men. Also he may have had some unpleasant repercussions from his own referrals to internists or to specialists. Either the medical treatment itself may have been unsatisfactory or the manner in which the internist related himself to the patient and to analysis may have had disruptive effects on the progress of the analysis and the analytic relationship. The analyst's aversion to dealing with medical problems which might come up in his analysis might be understandable on the above score. That still does not relieve him of the responsibility of finding an internist who has the qualifications essential to working with patients who are receiving analytic help.

Internist's Qualifications

The internist should be well trained in internal medicine and be competent in the diagnosis and treatment of physical ailments. He should be able and willing to devote the time necessary for sensing the emotional needs of each patient, obtaining a detailed history, doing a thorough physical examination, making the necessary additional laboratory examinations and prescribing the treatment required so that that patient will be willing to carry through with his request and return to him of his own accord if necessary. In short, he should have a feeling for the wholeness of the person he is treating—which naturally includes the physical as well as the emotional aspects of his being. The internist should be sympathetic to psychoanalysis. Indicative of such an attitude would be not only the frequency with which he refers his patients for such therapy but also the appropriateness with which he selects his patients for such treatment and the manner in which he educates them to their need for analysis and the values to be derived. For the analyst referring his patient, the internist's feeling for and understanding of the patient-analyst relationship would be crucial. The internist would not presume beyond his role. That is, he would not allow the patient to involve him in a concern with his emotional difficulties beyond what was necessary for the treatment of that patient's physical disorders. Nor would he investigate on his own the patient's functional disabilities beyond what was essential for him to know. If the internist is not versed in things analytic or is unsympathetic, several things do occur. Unwittingly he may find that the patient is using him as an auxiliary analyst, may try to substitute him for the analyst or try to play off one against the other. The internist may say things to a patient whose emotional balance is at the time rather precarious and cause serious difficulties in the analysis or even lead the patient to interrupt his analytic work. All of the above mishaps may occur where an internist is unsympathetic but in some instances may be due to intent, of which fact the analyst usually only becomes aware after a repetition of such instances.

The Internist-Analyst Relationship

Some of the difficulties with which an internist is confronted are due to the nature of the analytic relationship, and some are due to lacks on the analyst's side. An analyst may suggest to his patient that he see an internist to obtain a physical examination, have a check-up, or obtain treatment for some currently presenting physical symptoms. This suggestion may be made not only that it be done but also to discover what the patient's response might be to such a suggestion. Before the analyst has had time to contact the internist, the patient has already been to see him. More often the analyst fails to contact the internist at all. This may be due to reasons already mentioned. The importance of the physical has slipped away from him. Accustomed to obtaining all his own information about his patient, he will tend to think the internist will do likewise. That it is to the analyst's advantage to contact the internist beforehand is obvious. It is particularly important with certain patients who are upset at the time or have irrational attitudes toward physicians, physical matters or physical pain. Even if an analyst prefers not to give the internist information about his patient, he should so inform him. This situation might obtain when the analyst might want a completely unbiased report or when a patient for some reason insisted that the

analyst tell the internist nothing about him.

Alert Medical Consciousness

To return to the problem of dimming of medical consciousness among analysts, how can an interest in medical problems be developed, maintained and revived when it begins to fade? There are some immediate and ultimate solutions to this problem. One is the publication from time to time of articles such as this one. Another would be the development of a continuing relationship with an internist who fulfills the qualifications mentioned above. Continued association with medical or psychiatric institutions in a treatment, teaching or research relationship would have the same and additional values in this regard. I have noted that analysts who maintain such affiliations not only retain their medical and psychiatric orientation but also deepen it. A further stimulus would derive from a wider interest in psychosomatic relationships in general and psychosomatic disorders in specific. More should be written on the effect of analysis on physical disorders as yet considered uninfluenceable by analytic therapy. There is much to be learned about the values of analytic therapy in cases of progressive, incurable disease where an early or late demise is expected. Such interests would be stimulated by a greater emphasis in analytic training on a holistic viewpoint, which focuses on the individual as a totality and on living as a process. A trend in medical teaching is now favoring a closer integration of the organic and the functional. More time is being devoted to the teaching of psychiatry and to psychoanalysis. In time we can expect a closer relationship between analytic teaching and post-graduate medical training. Such alignments should allow for that freedom which I feel will be essential to psychoanalytic advances for a number of years to come. Arrangements which are restrictive can only be deleterious to the future unfolding of the possibilities that psychoanalysis offers.

Values of Medical Alertness

What are the values of an alert medical awareness? For the patient it would mean that everything essential was being done to maintain him in a state of physical well-being, and that his organic ailments were being cared for toward the end of cure, comfort or palliation. Also, the analyst could help his patient assume a more reasonable attitude to hours of work, recreation, vacation, sleep and rest. Where his patient might benefit from the supervised instruction of a person expert in improving body tone and body posture, he may suggest such personalized or group work.[1] Optimal physical status would remove or at least diminish one obstacle in the way of progress in analytic therapy. An interest on the part of the analyst in his patient's medical welfare would generally improve the patient-analyst relationship.

Although is is clear to the analyst what his function is, and although a patient may know consciously that it is not within the analyst's province to care for his physical ailments, a life-long connection of physician and physical disease is not so easily resolved emotionally. When the analyst does not fulfill the role of physician insofar as it can be his true concern, that interest is missed by his patient. When he does, it will mean that his patient will be receiving not only the necessary medical care but also will not have to suffer the consequences of too little, too much or the wrong kind of care. Also he will not be subjected to unnecessary operations. Likewise when operative procedures are necessary, the cooperation of the internist and the specialist will insure that they will be carried out, where possible, after adequate emotional preparation and under the least harmful circumstances to the patient. Also the analyst will have the comforting feeling that he is not analyzing someone whose problem is predominantly or primarily an organic and not a functional one.

Timing of Referral to Internist

At what points can the analyst bring to his patient's awareness a concern for his physical welfare and enlist the participation of an internist? It is my practice to obtain in the first interview or interviews information regarding physical illnesses, past or present, history of operative procedures, and present

[1] Gertrud Lederer-Eckardt, "Gymnastics and Personality," *Am. J. Psychoanal.* Vol. VII, 1947.

state of physical health. From such a start more detailed questioning may follow when necessary. If your patient is thin or obese, you might ask if he has always been of such weight and if it is a family characteristic or perhaps a physical disorder. At some point in the course of such interrogation, I might ask how long it has been since he has had a physical examination and if he has a family physician. If he has not been physically checked in some time, I suggest that he do so, and if he has no regular medical man, I recommend one. As soon as possible I try to arrange for a switch to an internist on whose judgment I can depend. From him I will receive a detailed report. A favorable one is pleasing and important to have. Should my patient need medical treatment at a later date, the internist has already made a contact and has a previous record as a basis for comparison. Likewise the internist and I have established a relationship with reference to this particular person. The internist is also in a good position to recommend that this patient return for an annual physical examination and also that he make regular visits to a dentist if he has not already done so.

I often make such recommendations and have therefore maintained a relationship with dentists who have a feeling for the whole person and for the problems with which we are concerned in analytic therapy. Most everyone has mixed feelings, rational and irrational, about visiting a dentist. Many have had unpleasant experiences surrounding dental work. They have felt that the work was done too painfully, was unduly prolonged, was too extensive, was of the wrong kind or too expensive and often had to be done over again. The latter often necessitated a further expense of time, pain, and money but also meant the loss of one tooth or more or even necessitated resorting to dentures too early. The commonest problems with patients in analysis are the fear and intolerance of pain and the inability to stand the sound of the dental drill. Some demand frequent use of novocaine. Others have a further problem. They can stand neither the pain of drilling nor the injecting of a needle which would introduce the novocaine. Sensitivity regarding oral or facial disfigurements from loss of teeth or from bridges and dentures is common. Attitudes toward aging come out very sharply regarding tooth loss. It requires considerable patience and understanding on the part of the dentist to keep such patients coming and accepting the treatment they require immediately to save their teeth.

There are other occasions when an analyst can make a referral to an internist. The occurrence of an acute illness, the exacerbation of a chronic one or the coming up in analysis of material regarding a previous but now quiescent physical disease, might offer such an opportunity. I feel it is the analyst's responsibility to refer his patient for medical care when he notes that physically his patient appears to be losing ground and when he cannot be certain that the persistence of certain symptoms is of an organic or functional nature. Hypochondriacal patients will more likely see medical men all too often. In such instances the analyst would want the patient to be seeing one internist continuously—one of his preference—in order to have some control over the situation and to be certain that he receives the medical care he needs and only what he needs.

Usually it is possible for an analyst to get a patient to visit an internist without much difficulty. Sometimes quite some pressure must be brought to bear. Only on two occasions have I presented patients with the ultimatum that they see a medical man or I would interrupt the analysis. In both instances it was obvious that they were severely and progressively more seriously ill physically. On one occasion, I accepted a patient for analysis with the prime motive of helping her to accept the necessity for an operative procedure which had been recommended by several physicians. I attained that objective in three months but the process had extended beyond complete extirpation.

Internist's Report to Analyst

The internist's report might be the clean bill of health you expect, but sometimes it contains surprises. At best an analyst obtains only a superficial physical history; he does not make a physical examination. In the course of analysis, however, a lot more

will come out regarding history. He will have many opportunities to observe, at least so far as the surface is concerned, his patient's physical status. The internist's direct questioning, his physical contact, laboratory or special examinations and the focus on the physical often bring out much more information which the patient had forgotten, overlooked or had a neurotic need to withhold from the analyst. The forgetting, unawareness or withholding of such information might also open up avenues of investigation productive for constructive progress in the analytic work.

The analyst may want a physical report as early as possible in his work with a particular patient. He may know that there is a history of a physical disease now quiescent which might flare up under emotional stress. The analyst would want the internist's assurance from time to time that the pace of the analysis is within a factor of physical safety for the patient. An exacerbation of such an illness will not only cause the patient unnecessary suffering and may necessitate his having to drop out of analytic work for a period of time but may even cause him to become averse to any further analytic work which would be essential to his future emotional and physical welfare. The analyst may know or believe that the internist may have palliative remedies for a physical disorder from which his patient is suffering. The earlier he obtains that relief the more comfortable will he be in analysis.

An analyst who is investigating the effects of analysis on disorders known to be affected by such therapy would want a report before, during, and after therapy. The analyst would particularly want such reports if he were investigating the effects of analytic therapy on physical disorders not yet definitely included in the so-called psychosomatic group. Reports from an internist would be essential to an analyst working with patients who have slowly or rapidly progressive fatal illnesses. Such information would aid him in the manner of the conduct of his therapy and his goals. In such cases, each analyst must make out with himself the goals in therapy. For myself I have functioned in therapy with the goal of an optimal result—as though my patient would continue to live. In my experience—and it is a difficult and painful one—such an attitude is most helpful to the patient and makes what time they have to live, months or years, that much easier and more fruitful.

Referral—Analytic Therapeutic Values

The analyst's interested participation in his patient's physical welfare can be productive for a greater understanding of his patient's character structure and can lead to an expanded knowledge of his life history—both contributing valuable material for the progress of the analysis. The request for a medical history in the initial interviews or the recommendation that a patient see an internist may bring into the foreground a number of attitudes toward the physical. I shall mention some of the commonest. The medical history can give us a picture of how certain attitudes have evolved. A person who has had much physical illness, depending on the kind and amount of care he received during such illnesses, might come to use physical illness as a way out of emotional difficulties or as a way of getting special privileges. Some people make a career out of being physically ill. They may also tend to recover ever so slowly and complain about the effects of a particular physical illness long after the normal expectancy for a recovery. Others, because periods of physical illness were so emotionally painful, might go to almost any length to cover up the fact of being physically ill, even when their malady is serious and they are suffering to a very painful degree. An overfocus on health and hygiene by parents may tend to cause a person to become hypochondriacal, overfocus on their bodies and use it for all manner of externalization. Then you might discover your patient has always been in good health, which favors the prognosis.

Attitudes Toward Health

Some people make a career out of keeping healthy, more as an abstraction than as a condition of their bodies or as a reality to themselves. They arrange a great deal of their lives around how long they work, play, sleep or rest, what food they eat and how long they go on vacation and where. I recall one man who at 65 looked about 45. Each

year he would go into a hospital for a period of ten days or so just to be checked up. To my knowledge he had never had a serious illness. At the other extreme was a woman who much enjoyed occasions of ill health whether minor or major. This was a lifelong pattern. From her bed she could dictate to everyone, make all manner of claims for special attention and special exemptions. During such periods her dictatorial and coercive manipulating attitudes came out in full flower.

One man had a terror of any physical symptoms or illness. For him it meant he had to admit of the existence of a body. He lived almost entirely in his mind. Later we became aware of his pride in the perfect body and in not growing old. Worst of all, being ill meant he could not be absolutely self-sufficient. The possibility of becoming physically ill put him into panic. In addition, the fact of having become ill was a terrific hurt to his pride in control through intellect. Being ill meant he had not foreseen to arrange that physical illness did not occur. His claims for immunity from the effects of living, time, and aging were considerable.

Although one man and one woman protested that the fact that they always looked frail and in ill health caused them considerable pain and anguish, we found that appearing in ill health had many values. In both instances their frailty was more apparent than real. Both had a considerable measure of physical vitality. While the first man quoted above had a fear of being or of looking sick, these latter two people had a fear of looking well. On the basis of looking not up to par, their unspoken claims for special privileges and dispensations were to be forthcoming without having to be verbalized. If a particular person was not so easily taken in, they could make him feel guilty by rather acutely appearing to look and becoming even more frail than ever. This looking under par had other values. If a well person did a good job, that was to be expected but if a person who operated under a disadvantage did well or even a little better, then such an attainment was to be applauded as something unique. And if they failed, they always had an out available. This aspect of their pride system was held onto with considerable tenacity. On occasions when they or I would comment on their looking better an immediate severe exacerbation of physical symptoms and actual physical illness would ensue.

Fear of becoming or being ill as a generalized fear can function much as a specific phobia, like that of heart disease or cancer. The phobia formation can appear with no previous or present history of physical symptoms and be as tenacious as where there has been some antecedent organic symptomatology on which to focus the phobia. The minor and major hysterias so dramatically portrayed in old psychiatric textbooks we rarely see nowadays in office practice. Pure examples of hypochondriasis, though not so common, are common enough and very frequent in less severe forms. Persons who massively externalize and use their bodies for that purpose are exhausting to work with. They constantly complain, feel abused, make claims to be assured nothing is or will be wrong with them physically. They are usually very vindictive and manifest it by complaining and tyrannizing through physical suffering. Attempts to get them to talk about themselves are usually met with deaf ears or an increased shower of complaints about their physical conditions, the unfeelingness of the analysts and the incompetence of medical men in general.

Indifference to the Physical Self

In the earlier phases of an analysis, when alienation may still be extreme, patients who have a pride in the perfect body often refuse to see an internist. They have the perfect body and perfect health—although you can see they are looking poorly and have already listed to you a number of obvious physical complaints, such as fits of nocturnal coughing or blood in their stools. Some patients seem not to understand you when you mention the physical. These are the people who are so alienated from themselves they are unaware of the existence of their bodies; they are only aware of their existence in terms of intellect, an abstract ethereal love, or in acting out. With some there is a positive pride in being above the earthly—above a concern or interest in their bodies, their physiological needs or the normal rhythms

of biological functions. One must distinguish between indifference to body and active self-destructiveness.

There are people who are accident prone, who know a certain treatment will cure or alleviate a physical condition they have. They will defiantly refuse to do anything about it. Often it is a race with time with such people—whether you can work through their self-destructiveness to the point where they will accept medical help before irreversible physical damage has been done. Because of their self-destructiveness, pressure must be brought to bear very cautiously. Ultimatums should not be used before you feel the analytic relationship can stand it. In an orgy of self-destructiveness they may interrupt their analytic work and then even that avenue of reaching them has been cut off.

Fears of Not Being Good Looking

Fears of being or looking ill or healthy are something quite different from the fear of not being good looking. This problem is particularly prominent in some women where there is great emphasis on externals. Vanity and conceit are prominent. Here the aid of a co-operative internist is essential, and usually through an interest in their appearance it is possible to get such women to see a medical man. If such women insist on going on unhealthy diets with drugs to lose weight or if they refuse to eat adequately to remain thin, the effects may be not so deleterious if under the supervision of an internist. His efforts plus the analytic work may bring about a more rational attitude before any serious damage is done. Likewise an internist by his own efforts and through his relations to specialists may diminish the number of unnecessary operations on the nose or breasts, for example.

Pride in Suffering

Special problems are presented by those people who have a pride in stoicism or a pride in suffering. To both are attached claims of considerable intensity. The patient who has a pride in enduring will tend to play down or pass off his physical difficulties. Even when you pile up evidence to show him he should see an internist, he will not budge. The person with the pride in suffering will exaggerate and dramatize real and imagined physical disorders but here again we run into the same difficulty. Mixed with the neurotic suffering is pride in martyrdom, humility, worthlessness and many other aspects of self-effacement. They may argue that it's selfish to be so interested in yourself. They will for long periods refuse to see an internist. In my experience where there is pride in suffering or enduring in the foreground, the other will become evident later on. In one instance, a patient oscillated from one to the other, almost from moment to moment, and made claims on the basis of both. Likewise with pride in enduring and in suffering there is usually much alienation and self-destructiveness. This combination presents quite a barrier to self-interest which would mean care for physical welfare when essential.

Attitudes to Physical Pain

Attitudes to physical pain will affect a patient's reactions toward necessary medical care or operative procedures. Patients who fear or hate physical pain usually have a pretty intense claim that life should be pleasant, easy, comfortable and made so by somebody. They will avoid treatment which might or which they imagine might be painful. If they finally accept the necessary treatment, they demand all kinds of assurances that it will not be painful. They demand all manner of anesthetics. In fact, many have reported the intense joy they felt at going into oblivion under a general anesthetic. The person who is proud of his stoicism would be above using fear of pain as an excuse. Usually he puts himself through unnecessary pain. He will bear the dental drill rather than ask for or even accept a suggested anesthetic. If an operative procedure is necessary he may select a spinal anesthesia so that he can look on and be conscious throughout.

Specific Help of Internist

There are a number of instances in which an internist can be most helpful to the analyst and his patient. The internist can aid in maintaining a patient in a state of health, bring relief for an acute ailment, prevent the exacerbation of an old one, give com-

fort for symptoms of a psychosomatic nature as well as those not expected to be alleviated or ameliorated through analysis. An internist can be most helpful in making referrals to specialists. The internist could act as liaison for the analyst in informing the specialist regarding this patient's needs and in maintaining contact with both specialist and patient throughout the specialized treatment. This would obtain whether or not analysis was concomitant with the specialized treatment and would be especially important if analytic work had to be interrupted for that period.

Genito-Urinary and Gynecological Problems

My patients' experiences and my own with referrals to genito-urinary surgeons and gynecologists have all too often had unpleasant repercussions. With the advent of penicillin and sulpha drugs, the treatment of actual or possible syphilis or gonorrhea can be carried on by an internist. A patient who has a phobia regarding either of these disorders is usually a very emotionally disturbed individual. There is not only the fear of the disease but also of being found out. There is also the matter of pride. A single male usually belatedly discovers that the woman he has been with is much freer with her favors than he suspected and hence might have either infection. In the married man the same might obtain, but in addition there is the terror of his wife's finding out or of his infecting her. With a woman there are the same problems in reverse and some additional ones: Might she become sterile? Will it interfere with her ever getting married? What if her present or future husband finds out? What effect might it have on her children? All of these circumstances require the utmost in understanding.

An internist can treat a number of menstrual disorders, but some he must refer to a gynecologist—including, of course, all conditions requiring operative procedures. As with a male patient but especially with females, treatment of genito-urinary disorders is generally emotion-laden because of the many involved attitudes toward sex. Only occasionally is a gynecologist consulted by a woman because of frigidity. More often it is because of pain associated with intercourse but most frequently because she cannot become pregnant. Involved with the last problem are all the attitudes a woman has regarding femininity and being a woman. Will her husband lose interest in her and even divorce her if there are no children? What will happen to her status in the eyes of her family, friends and neighbors if she is a childless wife? Will she be doomed to an incomplete and cheated life? These are not questions to be blandly handled at the level of a mechanistically viewed biology.

An internist may be most helpful in referring a patient to an understanding gynecologist for contraceptive advice. This is particularly a problem with unmarried women who do not intend to marry or are driven to have one affair after another. I feel it is the analyst's responsibility to encourage such women to get this help. Without such protection they live in constant terror of becoming pregnant or do become pregnant and have to submit to life-endangering abortions or enter into unhappy marriages. Usually they do not love the man. The marriage often breaks up, but frequently only after years of miserable living together. They stick it out for the child who also suffers from the loveless relationship.

Internist's Liaison with Surgeon

The internist can help in selecting a surgeon when necessary and in continuing his contact with the patient until he resumes his analytic work; and he can be helpful in other ways. Sensitive to the patient's needs, he can co-operate with the analyst in arranging the optimal time for surgery. He can be flexible when the analyst feels that pushing the date ahead would give him time more adequately to prepare his patient emotionally. The type of anesthetic, if this can be discussed, is important. Also a sympathetic internist will be able to understand that, essential as an operative procedure may be, the emotional repercussions would be far too great for the patient at that time. He would also be more mindful of possibilities for temporizing and even avoiding the procedure altogether. I recall one instance where an hysterectomy was advised for a number of sound medical reasons. By other methods

of treatment and by taking advantage of the involuting effect of the approaching menopause, the operative procedure was avoided and the result was advantageous.

Suicidal Attempts

Following suicidal attempts the prompt attention of an internist can be crucial. He can not only give the necessary immediate medical attention, but also promptly obtain the necessary additional aids, such as hospital admission, the use of a pulmotor and nurses for home care. Caring for a suicidal patient can be most trying. They become vindictively obstructive for having been interfered with in their attempt or become overcome with remorse and guilt and feel they should be allowed to die as a punishment. Often because they live so much in imagination they feel nothing will happen to them, so they refuse to co-operate on those grounds. Or they have been so affected physically by the suicidal medication that they cannot co-operate. The possibility of obtaining twenty-four-hour nursing and the co-operation of the internist may save a patient from being institutionalized with all the attendant reactions and consequences for the patient, the analyst and the analytic relationship. Although the internist may assume a considerable responsibility in such situations, the final responsibility must of course rest with the analyst.

Alcoholism

When working with alcoholics, an internist should always be in the picture. His task is to keep the patient in as good physical condition as possible over what always is a long therapeutic venture. He must do this by keeping the alcoholic under frequent supervision and work with him more intensively after his debauches. Often with the latter, there are intercurrent infections or bodily injuries of major or minor import. In one instance, an alcoholic during a prolonged debauch developed a severe cystitis necessitating prompt and active treatment. He had used an unsterilized catheter on himself without prior cleansing of the field.

Sedatives

On rare occasions I have given a patient one or two capsules of sedative. This I have done with patients who had such a pride in enduring they would exhaust themselves with nights of insomnia. On their own they would not visit an internist and certainly would not ask for a sedative. These people always have a great pride in control and self-sufficiency. It is only with urging that they will accept an occasional sedative. Their usual response is, "Are you sure I will not become a dope addict?" What they are expressing is a fear of becoming dependent on anything or anyone. All other patients should receive their sedatives from an internist and particularly those who may be suicidal. If told they must get them from him, they usually will not do so but may attempt even more aggressively to manipulate the analyst into doing so. Such a patient, if he gets sedatives from an internist, is less likely to use them for suicidal purposes since his relationship to him is not crucial. But if they are given to him by the analyst, he is likely to do so as a way of striking back at the analyst. He may often use the possession of a few capsules as a threat—or actually save them up over a period of time to be used for a suicidal attempt so arranged as to have the most vindictive effect possible on the analyst.

Besides the instances above mentioned are there any others where the analyst might function as internist? There would be no contraindication to suggesting an aspirin for a headache, some bicarbonate for an upset stomach or a cathartic for constipation. There would be no harm in this because most patients know this anyway. Also such a situation might be used as an opportunity to make the referral to an internist. By the time the analyst had agreed with such a prescription twice or three times, his patient might well be under the care of the internist. The analyst could then more easily suggest that the responsibility for the treatment of such physical ailments is rightly the internist's province. That leaves practically no instances where an analyst actually prescribes medication for his patient—which is as it should be. Why?

It is a value-proven rule that the analyst should neither examine nor medically treat his patients. Analysis is difficult enough without taking on the additional burden and

complication of medically treating patients. Besides, analysts devoting themselves wholly to analysis cannot keep up with the latest medical advances as an internist can and does as his exclusive interest. The complications arising from an analyst's examining a patient of the opposite sex—particularly of a male analyst examining a female patient are immediately obvious. A physical examination would definitely complicate the analytic relationship as would prescribing of medication. The difficulty is that those patients who insist on medical treatment also are the ones who would not be satisfied with medication for minor ailments. Their demands would become more and more extensive and major. Also if the analyst should prescribe, the patient's use or misuse of it would be another complication. In short, I have rarely seen medical intervention on the part of the analyst end in anything but unpleasant consequences for the analysis.

Reasons for this Article

A final point. If there is this dimming of medical awareness on the part of analysts, how could this article—which indicates rather an alertness to such questions—be written? Because of my training and because I found as well as placed myself in a sequence of circumstances over the last eighteen years. First, there was a postgraduate training period of five years in medicine, neurology and psychiatry. Then followed over nine years as chief of a division of neurology and psychiatry in an acute 1,000-bed hospital, with its large out-patient department. Here a special circumstance obtained which is the same for all those who operate on a service of neurology and psychiatry in a large general hospital. It is in the spirit of the situation that all other services can freely make or not make psychiatric diagnoses and be in error. But even after transfer from any other service, the psychiatrist or neurologist must not make the error of overlooking the presence of organic disease of any variety outside his specialty. As a result they feel themselves under a constant test situation of diagnosing organic disorders overlooked on the other services. Often these diagnoses are made because of constant rechecking; often they do not represent an oversight on the part of the other services but are made because such conditions become sufficiently obvious only at some later date. Most of the conditions which fall in this latter category are those organic disorders which can for a long period of time masquerade as functional illnesses.

For the above two reasons, an alertness to the possibility of concomitant organic disease became an embedded part of my orientation to therapy. Then my training, subsequent practice of analyst and functioning as a training analyst and teacher before, during and since World War II made it possible for me to view somewhat kaleidoscopically a series of rapid changes within the field of psychoanalysis and of psychoanalysis within the whole scheme of things. Since I have an interest in medical problems in psychoanalysis and because by training and experience I have felt myself suitably placed to do so, I have written this paper for the information it conveys, as a stimulus to interest more in such problems, and as an expression of my concern regarding a dimming of medical consciousness among analysts.

"THE MAGIC SKIN"

A PSYCHOANALYTIC INTERPRETATION

I. PORTNOY *

IN his novel *The Magic Skin*, Balzac demonstrates profound insight into the sources of human suffering. The theme of this book is the devil's pact—that pact in which a human being sells his soul for glory and unlimited power and pays the price of self-destruction and death. In the light of modern psychoanalysis this pact expresses the neurotic individual's attempt to escape from his conflicts by erecting and worshipping an illusory, glorified self, which results inevitably in his becoming increasingly alienated from his real self and finally in turning destructively and vindictively against it.

The three elements in the devil's pact are (1) the person in crisis, (2) the pact, and (3) the resulting descent into hell.

THE PERSON IN CRISIS

Raphael de Valentin is the protagonist of Balzac's human tragedy. We meet him at the moment of crisis in his life when he is about to commit suicide. Subsequently we are given a short biography of his previous life, through which we learn enough about him to understand something of the neurotic development of his character which brought him to the point of crisis.

Of his family origins we know only that there was a great deal of family pride in aristocratic ancestry. Raphael was an only son. We know nothing of his mother who died early in his life, so that the dominant person in his childhood was his father. His father is described as "tall, thin, slight, hatchet-faced, pale, silent, fidgety, exacting, flinthearted and frigid," a man who covered the boy's merriment with "a leaden pall" and received the boy's effusive demonstration as "childish absurdity." Here was a man who was apparently devoted to his son, but we can recognize in this devotion the disregard for the child as a person in his own rights which is so damaging to a free and healthy development of the self. Much of the father's interest in the boy lay in his desire to "make a statesman out of him" so that he could thereby restore the glory of the family. The father's predominant trends were apparently detachment and aggression, and the boy's need for "a mother" received no satisfaction from that source. Raphael says that he attended school till the age of 17 and found it very pleasant. His difficulty apparently came out in the open when he returned home to the severe strict discipline of his father. He was predominantly compliant toward his father. He describes himself as timid, obedient, submissive, afraid of his father, "a young girl married to a skeleton."

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Though he cowered under the strict despotism of his father and apparently devoted all his energy to carrying out his father's wishes in regard to his further career, we have some evidence of the hostility which he felt for his father. We know that he chafed at the restraints imposed by his father, that he was aware that his father "never left him to himself," that he often planned to run away and suffered despair which he "soothed by slumber." We know also that he needed to repress his hostility, apparently defending his father's severity by believing that "at heart he was all right. His severity had its sources in greatness of character and pure morals." He solved his conflict mainly by retreating into fantasy and by detachment. He describes this detachment well when he says "instead of feeling things I weigh and consider them."

Up to this point in Raphael's story we have had attributed to the father Raphael's drive for glory, for reinstating the family's pride and prestige. While his father lived, the striving for glory was expressed in hard work, study, realistic striving for success. Note that this was not out of any desire to fulfill himself or out of an interest in his field; the self, in other words, has been left behind. It's talents and energies have been put in the service of the "father's" search for glory. His own wishes for glory were expressed at this time only in fantasy in which, already, "love" represented the great solution. In these fantasies he saw himself possessing a mistress who would be a fit partner for that imaginary self which he now described as "a passionate temperament, tenderest soul and most artistic nature." This mistress would be submissive to him and would open the doors of the upper world to him with her wealth, beauty, and social position. (Actually this is the beginning of the "pact"—his dedication to glory and an illusory self.)

When Raphael's father dies, we begin to become aware of the degree to which the striving for glory was now his own, motivated entirely by his own needs. The chief emphasis now is placed on achieving the feeling of greatness in his imagination. I feel that this was necessary because his ambition and neurotic goals were so very unrealistic when compared with what he actually was—a timid, shy person, awkward, weak, lacking in confidence. In his imagination, then, he is able to rise above his own feelings of helplessness and inadequacy and chiefly above the conflict within himself between his strong compliant tendencies and his aggressive trends.

How does Raphael see himself in his imagination? He describes himself as sincere, simple, innocent. He sees himself as the great lover whose capacity for feeling and loving he describes as a treasure. He sees his passions, which actually represent intense neurotic needs for affection, as great gifts which he is ready to offer the woman of his dreams. He sees himself possessed of great charm and appeal for others. Later he begins to take great pride in what he calls his "splendid powers." These powers are those of a great author, a great scientist, a great intellect. "I possess the power of readily expressing my thoughts, and I could take a forward place in the great field of knowledge. The emotional part of my nature was refined till it became the perfected instrument of a loftier purpose than passionate desires." These powers, he says, resulted from the isolation in which he was compelled to live because women did not accept him. Here we begin to see one of Raphael's favorite devices. In addition to idealizing his defects and seeing them as virtues he also invests with pride his defenses.

He sees himself as the creative artist, the man of genius, but this picture is so fantastic that he needs affirmation by a mistress who will "gyrate" around him. He describes this state of mind as "aggressive egotism," which is an excellent term since it tells us that predominantly Raphael wanted not only "love" but power, prestige, and, through recognition, satisfaction of both his dependent and aggressive needs. He was ready to give up his life for this but at first felt that he could not degrade himself to obtain this. He expresses his egocentricity in his description of the kind of wife he wants to have. "She who is really a wife, one in heart, flesh and bone, must follow wherever he leads, in whom her life, her strength, her pride, and happiness are centered. Ambitious men need these Oriental women whose whole thought is given to the study of their requirements."

Raphael speaks of himself as a man of genius, though he has as yet created nothing to warrant this. This is really what he means when he speaks of "scaling the heavens without a ladder"—achieving glory without effort. As his claims are frustrated more and more by his own reality and by the failure of the world, especially women, to recognize his greatness, he reacts by soaring even higher in his imagination. He begins to speak of his own overweening ambition, later describes himself as a "glutton" whose ambition knows no bounds. "In dreams I would often dream myself a general, nay emperor; I have been a Byron and then a nobody. After this sport on these pinnacles of human achievement, I became aware that all the difficulties and steeps of life were yet to be faced. My exuberant self-esteem came to my aid; I had that intense belief in my destiny which perhaps amounts to genius in those who will not permit themselves to be distracted by contact with the world." Here we see him idealizing "detachment," but actually he needed people too much to allow this to be a "successful" solution.

Later, in speaking of his book on the human will, Raphael reveals his grandiose conception of himself, his brain, his will which can magically control the universe. "Human will is a material force like steam; in the moral world nothing could resist its power. If a man toughens himself to concentrate it, to economize it, and to project continually its fluid mass in a given direction upon other souls, such a man could modify all things relatively to man, even the peremptory laws of nature. Our ideas are complete organic beings existing in an invisible world and influencing our destinies, for example, Descartes, Diderot, Napoleon who directed all the currents of the age."

However, Raphael's soaring is still not sufficient to blind him to reality. He is still "distracted by contact with the world" and himself as part of this real world. Though he believes himself to be fated for great things, for the attainment of power and a great name in literature, his worship of an illusory idealized self has resulted in a great increase in the low estimate he had previously had of his real self. "My opinion carried no weight with me. I took no pleasure in myself. I thought myself ugly and was ashamed to meet my own eyes. I felt myself to be nothing." (Here, then, are the real beginnings of the "hell," the turning against the self which is the result of the devil's pact.) Now Raphael needs desperately to bridge the greatly increased gap between his idealized and despised self. For this purpose he needs affirmation from the outside world of his imaginary greatness. When this is not forthcoming, when he fails to obtain "the complaisant mistress who would weave crowns for his head as he stood on his pedestal in his Godlike superiority," since he could not completely identify himself with his idealized image, he begins to invest his mistress dream with a new element. This new element becomes a crucial factor in his life. He externalizes his striving for glory to a woman who would possess all of the greatness which is still out of his reach. This woman would be a queen, a Goddess who would give herself to no one but him. He would be the envy of all the young men in the smart set, men who he felt were worthless compared to him but who, nevertheless, succeeded with women where he failed. With this one triumph, the possession of the queen Goddess, he would once and for all triumph over these men and in their envy reinstate his own pride. A mixture of feelings is involved here. First is the element of vindictive triumph which he would achieve—"I would dominate the feminine intellect and so have the feminine soul at my mercy, thereby revenging myself on society." In this we see his pride in the ascendancy. Also, however, his passive, dependent, compliant tendencies, reinforced by self-contempt and expressed in his morbid dependency, would be satisfied. "I meant to cover myself with glory and to work in silence for the mistress I hope to have one day. For me all women were of one type. In each and all I saw a queen, and as queens must make the first advances to their lovers they must draw near to me, to me so sickly, shy and poor. For her who should take pity on me, my heart held in store such gratitude over and beyond love, that I had worshiped her her whole life long." Here, also, we see the emphasis on and use of suffering by the dependent person.

At this point Raphael glimpses the reality of himself and his life, which he describes as a "lonely, ghastly desert." He sees his isolation, his lack of friends, and speaks of the world as inimical. He becomes aware of the poverty of his real existence and of himself as compared with his imagination. He despises his weakness and dependency. That he would see the world as inimical is inevitable, not only as a result of the essentially inimical influence of his father, but also because of the constant blows to his pride which he experiences when his exorbitant claims and expectations are not fulfilled. At this point Raphael is in danger of sinking into the pit of his own self-contempt. He avoids this by adopting a new solution which will help him achieve glory. The solution is work, the writing of two books. One will be a play which will bring him wealth and fame. The other is a scientific treatise on The Will which will bring him recognition for his intellectual superiority. He plunges into this project with great passion and energy. Later he realizes that actually there was little of the creative in this, that it was still part of the "one grand thought for a mistress." In his enervating and energy-consuming "trances" he dreams of luxury, self-indulgence, fine clothes, beautiful mistresses, soft cushions, orgies. Nevertheless, he is willing to sacrifice all for three years in order to achieve his own particular conception of glory.

Here we get a picture of some of Raphael's constructive forces. Certainly he had considerable energy and capacity for work. He was able to deny himself and dedicate himself to the task at hand. He could even give up his need for intimacy in order to fulfill this task. Unfortunately, however, his energies and talents are put in the service of his striving for glory, the fulfillment of the demands of his own idealized image rather than in the service of himself and his own human being. He invests his self-denial with pride and sees his ability to do so as yet another triumph. He luxuriates in his suffering and visualizes that at the conclusion of his work not only will wealth and prestige come to him but also the wealthy, well-dressed woman of his dreams, who should some day say softly, while she caressed his hair; "poor angel, how thou hast suffered!" Here Raphael reveals the crucified Saint in his idealized image. His suffering, neurotic and real, and his abused feelings, are thus put into the service of his striving for glory, and, once again, we see how completely dedicated he is to this striving.

Raphael carries through his resolution, which actually constitutes a kind of deal with life. But the world refuses to fulfill its part of the "deal." His comedy, which he regards as a masterpiece, is greeted by others as a "babyish fiasco." The jokes of his critics "clipped the wings of a throng of illusions, which have never stirred since within me and left deep wounds in my heart." Raphael risked a great deal in the writing of these works. He put his illusions of greatness as an author to the test of reality. There was no question in his mind of a persistent effort to learn, to write, to examine his writing, see wherein it was defective, take constructive steps to improve it, etc. This was to be a masterpiece, quickly accomplished, and the world was to acclaim it as such. When this expectation is frustrated and yet another blow struck at his pride, he has no choice left but to return to his previous solution, the "love" of a noble woman of high station.

We are able to see that Raphael was actually incapable of accepting love, that he was, indeed, not really interested in love at all, in the episode that concerns Raphael's relationship with Pauline. Here a young girl unselfishly and honestly offered him her love and devotion. Raphael could see her only as "my child, my statue. I a Pygmalion." He rationalizes his inability to love her and here we see his pretenses of goodness and consideration. Actually he does not hesitate to use and exploit her. He cannot "love" her because she does not fit into his dreams of glory. She is not the queen who can affirm his kinghood, relieve his doubts and still his self-contempt. It is as if Balzac, with pitiless completeness, wished to strip away any illusions the reader might have about his hero. He wishes us to know that the love for which his hero was sacrificing himself was a pretense. Raphael himself is aware of this, but his striving for glory is so compulsive, since the alternative is now the pit of self-contempt, that he must continue in his en-

deavor. "Truly I have scorned myself for a passion for a few yards of lace, velvet, and fine lawn, and the hairdresser's feats of skill, a love of wax lights, a carriage and a title, a heraldic coronet painted on window panes, or engraved by a jeweler; in short, a liking for all that is least womanly in woman. I have scorned and reasoned with myself, but all in vain." But Balzac is talking here about something infinitely more significant than Raphael's preference for glitter and glamor rather than solid worth. He is also talking of Raphael's great betrayal of all that was solid and worth-while in himself, of his worship of the glitter, the glamor and sheen of his spurious image of himself, since the noble queen he sought to worship was an externalization of his own image.

Certainly Pauline's love could have helped Raphael, whose life had really been such a loveless one. But we see that his entanglement and absorption in the striving for glory made it impossible for him to appreciate and accept this help. Raphael's defeat in his writing endeavor marked the end of his brief creative period. At this point Rastignac enters into the picture. He is another of the devils who appear and reappear in Raphael's life. Rastignac represents not an external tempter but actually the appearance of an auxiliary solution to bolster the structure which has been so shaken by the repeated blows to his pride. It represents also an effort to bridge the gap between his idealized self and despised self. The solution which Rastignac embodies is cynicism. Previously Raphael had pretended to himself that what he wanted was something fine and good, that he himself was moral and pure, essentially constructive. At this point in his development, however, he casts aside morality and accepts Rastignac's "realism." Through Rastignac he meets Fedora who represents, as Raphael puts it, his last chance for glory, his final ticket in the lottery. On the one hand he does not really see her as she is at all, insists on surrounding her with an air of mystery, insists on seeing her as a very feeling person, a lofty soul, who is temporarily withdrawn because of an unfortunate marriage into which she had been forced. On the deeper level, however, he sees her quite well. The Rastignac in him sees her as cold, domineering, "a woman who can only feel pleasure through her brain. Happiness for her lies entirely in a comfortable life and in social pleasure." Rastignac warns him "her sentiment is only assumed. She will make you miserable. You will be her head footman." Yes, Raphael sees her with his inner eye and, indeed, the picture is the perfect reflection of his own pride, arrogance, aloofness, emotional deadness, shallowness, pretenses of feeling, vanity and egocentricity. Truly, he had become a "footman" to his own idealized image. Fedora is Raphael's idealized image, and he worships her because he has lost all faith in his real self and has dedicated himself completely to his striving for glory. He sees himself as "every inch a queen" but "suffering under the iniquities of an ignoble world." He attempts first to "assume a little authority" with her but, of course, this fails. Then he comes out into the open with his intense morbid dependency. I think that the poignancy of his need here can be understood fully only if one keeps in mind the fact that it is really his own idealized image that he is trying to placate so that he can be spared the ravages of his self-contempt and self-destructiveness which were becoming ever greater though he tried desperately to keep them out of the picture. Further, Raphael needs at all costs to relieve the feeling of being unlovable, of being the very opposite of the adored princess which he is in his imagination. Raphael also needs Fedora to achieve a vindictive triumph over the world of women who had rejected him, by possessing her and eventually enslaving her. He needs her to triumph over the world of men who had refused to accept his superiority. He needs these triumphs to restore the pride which has become almost the sole basis of his existence. No wonder, then, that he says, "death or Fedora." He lays siege to her with many devices. First he tries to appeal to her by "engaging her intellect and vanity, plays up to her self-esteem." He loses himself utterly in her. He attempts to seduce her with his knowledge and his wit. Characteristic of the morbidly dependent person is the fact that with those who admired him he could be surpassingly charming, witty and clever in conversation, but with Fedora who did not respond he be-

came mute and dull. He tries to make himself indispensable to her, necessary to her vanity and comfort, "a slave always at her side." Everything else in his life is forgotten in the face of this all-consuming campaign. He fritters away his time, his talents, his money, his relationships with others. He appeals to her with his sacrifices and suffering, hoping at least to evoke pity if he cannot evoke love. He threatens and cajoles, storms and begs by turn, to no avail. Throughout this, while he can still pretend to himself that his feeling is one of love, he can still protect his pride to some extent. When finally he sees that actually he is in bondage to her, his pride suffers a terrible blow, but his dependency is too great to permit him to stop. When all other measures fail, he uses one final device—he goes to pieces, publicly "kills himself" so that she will be aware of the extent of his suffering and his need, so that she will know she is destroying him, and through pity or a feeling of guilt accept him. When this too fails, all hope is lost and, indeed, for Raphael life has ceased to have any value. Rejected by himself from the very start, he has now been rejected by his pride and by his queen. He turns to his final solution which is resignation.

For Raphael resignation represents his turning his back not only on his real self, which he had done long ago, but also on his ambition. He leaves his "great work," *The Will*, and enters with Rastignac into an orgy of debauchery in which all that matters is the enjoyment of new sensations. Balzac gives us an excellent description of this solution and its subjective value for the neurotic. "Excess comprises all things; it perpetually embraces the whole sum of life; it is something better still—it is a duel with an antagonist of unknown power, a monster, terrible at first sight, that must be seized by the horns, a labor that cannot be imagined. A world where everything is wonderful, where every ache of the soul is laid to sleep, where only the shadows of ideas are revived. The prodigal has struck a bargain for all the enjoyments with which life teems abundantly, at the price of his own death, like the mythical persons in legends who sold themselves to the devil for the power of doing evil." He takes to wine to deaden what is still alive in him. "All men and all things appear before you in the guise you choose; in those hours when wine has sway, you are Lord of all creation." He takes pride even in this terrible orgy of self-destruction, says that all great men have been either pleasure-loving or base. Nevertheless, he cannot still his hopelessness and despair, nor his bitterness at the low state in which he finds himself. He feels terribly abused—"it was my misfortune to be deceived in my fairest beliefs, to be punished by ingratitude for benefiting others. The contagious leprosy of Fedora's vanity had taken hold of me at last. I probed my soul and found it cankered and rotten. I bore the marks of the devil's paw upon my forehead." In spite of his abused feelings, in spite of his blaming others for the consequences of his own search for glory, in other words in spite of his externalizing, he cannot escape his self-contempt except by the incessant distraction of pleasure and wine. As he says, he wishes never to be alone with himself, he needed constantly to have "false friends, courtesans, wine and good cheer to distract him" from his self-loathing. Finally the money needed for these incredible excesses runs out. What remains of his pride makes a life of poverty, begging and borrowing, intolerable for him. Doing something through his own efforts is impossible because of his resignation and the inertia which underlies his activities. This is what Raphael calls "the unheard-of sufferings for which language has no name." Nothing is left for him but to complete the self-destruction on which he had embarked by actual suicide. At this point he encounters the final devil with whom he makes his fatal pact.

The Pact

Although Balzac creates this drama in such a way as to make it appear that the pact is actually made at this point, he really makes it quite clear that Raphael's pact with the devil was made long ago. As a matter of fact the tragedy of Raphael's life, the result of his striving for glory with its resultant alienation, self-contempt, morbid dependency and finally resignation, was almost over when he met the final devil who offered him omnipotence in exchange for his life. The words on the magic skin tell the terms of the

contract very clearly. "Possessing me thou shalt possess all things, but thy life is mine, for God has so willed it. Wish and thy wishes shall be fulfilled. But measure thy desires according to the life that is in thee. This is thy life. With each wish I must shrink even as thine own days. Wilt thou have me? Take me. God will harken unto thee. So be it." The devil offers Raphael unlimited power, greater riches, more power, "more consequence than a king." With no thought, his striving for glory revived in this magical way, Raphael recklessly accepts the terms of the pact. We must note that this is the first time that Raphael has actually succeeded, through magic, in achieving his striving for glory, which is now seen to be nothing less than the striving for Godlike omnipotence.

The Hell

Again, it is really not at this point that the Hell begins. Raphael was actually going deeper and deeper through various levels of hell from the moment that he began to live in imagination. Up to this point, however, the Hell represented the first of the two tragedies of which Horney speaks—the total desertion and abdication from the real self, from all that was potentially good, creative and worth-while in himself. The final hell which now appears is the vindictive destruction of the self.

When Raphael finally realizes that, in return for unlimited power, for wealth, for prestige, for having others at his feet, for vindictive triumph, for the magical fulfillment of all of these, he has put himself completely at the mercy of the devil, the pride which will be satisfied with nothing short of total destruction of the self, he becomes terrified of death. The conflict within him is the ultimate human conflict between good and evil, between the pride system, with its destructive forces, and the constructive forces of the self. He attempts to solve this terrible conflict by complete renunciation of the self and the pride, by resignation. Since every expression of the "I"—I wish, I will, I desire—meets with a vindictive repercussion from the destructive pride, he attempts to give up wishing and willing anything at all, to become vegetative. He cannot, however, crush completely that which is vital in him. Some human sympathy and helpfulness emerge in spite of his efforts to crush them when he helps his former teacher. There is an immediate self-destructive reaction as the skin, symbol of his life, shrinks. When Pauline reappears, he is unable to prevent his feeling love and desire for her. Certainly there was much in this love that was neurotic. It appeared only when she was wealthy and beautiful, that is to say a replica of his glorious ideal of womanhood. Nevertheless, I feel that what was still left of a capacity to love genuinely also emerges. Again he cannot crush his own spontaneous feelings and again he suffers a vindictive reaction from his ruthless pride. He attempts further to restrict his life, to escape feeling, but the process of self-destruction relentlessly continues. While he has attempted to renounce his pride, he shows his unconscious duplicity by appealing to his magical powers to kill his opponent in the duel. Certainly, having so much power, he could have protected himself in some other way. There is some fleeting sympathy for the young man, but he finally crushes him with little feeling. Symbolized here, also, is the fact that, while attempting to save his life, he had really not turned back to himself, the only possible source of his salvation, as, indeed, he is too completely caught in his conflicts to be able to do so without help. The incompetence of scientists and physicians to prolong his life without the knowledge of the struggle going on in him, is clearly described by Balzac.

In his last days, having gone through the fires of his hell, Raphael finally feels "the need of close contact with nature, with natural emotions." In effect, of course, he is feeling man's yearning to return to himself, that yearning which I believe Balzac also saw as man's great hope for salvation, the yearning which he says had lain dormant in Raphael for so long. At the end Raphael acknowledges his feelings for Pauline, and the devil exacts his final price, the man's life. While Raphael must pay the price of his pact with the devil, I feel that his redemption at the end represents a victory of good over evil.

Summary

The devil's pact has been a subject of

interest to many throughout the ages. Many great novels have been built around this theme. It has remained for Horney to shed the light of modern psychoanalysis on this crucial problem, to confirm it clinically, to link it with other basic elements in the neurotic character structure, and, finally, to see its crucial significance for therapy of the neuroses.

When the neurotic individual attempts to escape from his inner conflicts by self-glorification and the erection of an idealized self, he takes a step which has disastrous consequences for his life. His reality, with its flaws and limitations, comes to be hated and contemptible to him. He turns away from it, but it remains to mock his visions of glory. Vindictively, he turns against this despised self and attempts to destroy this crowning insult to his pride. Attempting to escape the terror of his self-destructiveness, he renounces both his neurotic as well as his healthy human strivings. The self, though it has been greatly weakened during the course of the neurotic character development, nevertheless remains alive. Each assertion of this aliveness evokes a destructive reaction from its implacable enemy, the pride, and finally the self succumbs. Raphael is, of course, his own executioner, and his death is a suicide.

BOOK REVIEWS

INDIVIDUAL BEHAVIOR: A NEW FRAME OF REFERENCE. By Donald Snygg and Arthur W. Combs. 386 pp. Harper & Bros. $3.50

ATTEMPTS to understand the behavior of an individual are essentially of two kinds: those which are based on the inner plan and purpose of the individual doing the behaving, and those based on the plan and purpose made of the behavior by the individual doing the observing. This book is an exposition and an espousal of the former frame of reference, namely the "personal" world of the individual. It also presents a theory of human motivation which should be open to examination on its own, regardless of the frame of reference from which it is seen. The theoretical conclusions are then applied to the fields of social organization, education, abnormal behavior, and psychotherapy. This book therefore consists of many parts, with a unifying principle running through them, and all dealing with important problems and raising important questions.

For the psychoanalyst, this book is of interest in several ways. It represents a sharp departure from the "objective" frame of reference which much of academic psychology has generally been following and is bold in accepting and defending on scientific grounds the personal one it advocates. It adds confirmation of the essential rightness of the direction psychoanalysis has taken in recent years as to theory of human motivation and therapy. It makes contributions of its own which may in turn be of use to psychoanalytic theory. These are not the conclusions of the authors of this book. Although they acknowledge that the impetus for their point of view first came from Freud, they have little to say about psychoanalysis generally and nothing about the contributions of Adler, Fromm, or Horney. They would not agree that psychoanalysis operates more than partly from the basis of the personal world of the individual. They say nothing about the relationship of "free association" to the method of therapy which they feel more wholly allows the individual to reach his inner meanings, namely, the non-directive approach. Nevertheless, the implications for psychoanalysis are there.

We may now examine parts of the book in somewhat greater detail. First, as to the frame of reference involved: Individual behavior, say its authors, has its logic and reality in the private world of the behaver and can best be understood and predicted only when that private world is known. This private world may be spoken of as consisting of what the individual considers as himself (the "phenomenal self") and what he considers as being outside of himself (the "phenomenal field"). A subdivision of the phenomenal self would include that which the individual considers as closest to himself, the "self-concept." These are not static entities but keep changing, though at each instant they are organized wholes. As they change, elements which may have been in the background at one time may come into focus the next, and vice versa. It will be recognized that in this formulation the

authors make use of principles from gestalt theory and the field theory of Kurt Lewin. It is not too different from saying that the character structure of the individual will determine the concept the individual will have of himself and his world. But it is also saying that the behavior is the resultant of what is in cross-section at the time of acting. The "cause" of his behavior must be operating at that time. This is in line with analytic practice which attempts to see the past in the present (and the present in the past).

This formulation makes it possible to explain psychological functioning like remembering, forgetting, learning, the concepts of "conscious" and "unconscious" and others in terms of differentiation into figure by the phenomenal self from the phenomenal field. In the phenomenal field there may be elements of a low level of differentiation, dating from childhood, when perceptive tools were inadequate or the phenomenal field too threatening, although such elements "may affect later differentiations while never appearing with sufficient clarity to be effectively dealt with." Similarly, elements may be repressed to a low level of differentiation after once having been in clear focus.

These examples are given to indicate the nature of the understandings which this formulation makes possible. It may be characterized as psycho-physiological, and at certain levels of inquiry it can be very illuminating. But by itself, it is not motivational but rather descriptive. It is helpful in that psychological functioning can be put in clear terms and makes unnecessary mystical suppositions. It opens some of the questions to possible experimental validation.

We now come to the theory of human motivation presented in this book. The essential goal of behavior is the maintenance and enhancement of the phenomenal self. The authors discard a motivation based on instinct. Such a concept would not be in accord with the striving for unity which they see as an essential characteristic of all life. All efforts of the organism are part of the one aim to maintain and enhance its phenomenal self. What they actually include under this concept may be gathered from what they consider to be the techniques that the individual uses to attain this goal. They are: "by mastery over people or things; by identification with a powerful individual or membership in a potent group; through bringing about some physical change in the body organization" (e.g. alcohol). If the motivation is to be judged by its techniques, some of it could be classified as neurotic. The difference between normal and neurotic behavior is not well drawn. The authors do not, for instance, distinguish between healthy and neurotic conflict.

To give a precise statement of the authors' concept of a neurosis is not easy. It is intimately linked with the mechanisms of their frame of reference. It is essentially a state of threat due to inadequate differentiation of the phenomenal self in the phenomenal field, leading to further difficulties in perception and differentiation and a further increase in threat. The organism cannot accept all aspects of reality. Change becomes increasingly difficult. The organism has to resort to techniques of defense. Early failures at maintaining and enhancing the phenomenal self due to environmental or other causes sets the process off.

As far as the above formulation goes, it is not incompatible with the later developments in analytic theory. But it does not go far enough. It lacks the sense of dialectic change which would explain the perpetuation of the process, such as the development of an intricate pride-invested self-system to maintain unity against increasing threat.

The authors define therapy as "the provision of experience whereby the individual is enabled to make more adequate differentiations of the phenomenal self and its relations to external reality." They divide therapies into "inductive" and "self-directive" (non-directive) methods. To effect change, all methods must in the final analysis depend on the individual himself making the change, after making more adequate differentiations in his phenomenal field, becoming aware of his "own personal meanings." Since the diagnosis of the phenomenal self and the determination of the phenomenal field by the therapist is an extremely difficult matter and may be influenced by the therapist's own phenomenal field, the authors feel that the non-directive (self-directive) approach offers fewer possibilities of error and greater

accuracy of direction. From the point of view of their concept of neurosis, there can be no disagreement. Working with what is thought to be a somewhat more comprehensive concept of the neurotic character structure and utilizing methods of free association, it should be possible to make fewer errors in a somewhat more active but still cautious attempt to help the individual patient at self direction.

There is a good deal more in this book that deserves comment. The discussion of education, for one thing, is enlightening and challenging. It is in this field that their theories and the particular formulation of them seem most clarifying and applicable. They point out how important it is for the child—and for all of us—that more emphasis be given to what the process does to the child rather than to what he "learns." But not only in the part dealing with education, but throughout the book there are valuable observations and formulations, although one may not fully agree with all of them. There is also present in the book a sense of unity and high purpose that stems from the realization of the crucial importance of the implications of a psychological theory of human behavior if it is taken seriously. This book has great merit and can prove a stimulating experience to students of human behavior.

—Bernard Zuger, M.D.

Oedipus—Myth and Complex. By Patrick Mullahy. Introduction by Erich Fromm. 538 pp. 1948. Hermitage Press. $5.

Patrick Mullahy, a psychoanalytically oriented philosopher, has attempted in this book to elucidate the points of view about the Oedipus complex held by the proponents of the various psychoanalytic schools. While doing so he has summarized in an understandable fashion the more important works produced by his authors, thus providing the reader with a well-rounded review of psychoanalytic theory. The authors discussed include Freud, Adler, Jung, Rank, Horney, Fromm, and Sullivan.

The first four chapters are devoted to Freud and his disciples—notably Abraham, whose contribution to the study of character is given wide prominence. This section of the work is excellently done; Mullahy seems to have distilled the essence of Freudian theory out of the maze of obscure, elusive, and confusing ideas so often set down on paper by Freud. And he portrays very well Freud's inherent pessimism in the following passage, quoted from his paragraph on the death instinct: "In fact, in Freudian theory human nature is burdened with an insoluble and terrible dilemma: One must either divert his aggressive, destructive instincts against others or turn them against oneself. Thus, Freud finally worked out a theoretical explanation for his almost unmitigated conviction of the inherent evilness of man."

Mullahy devotes a great deal of space to the concept of symbol, showing how the symbol is to Freud "a mode of expression which has never been individually acquired," while to Jung it is an indication of what is to come. To Jung symptoms of neurosis (i.e. symbols) "are not merely consequences of causes that once have been. . . . They are endeavors toward a new synthesis of life."

Freud's theory of the origin of the Oedipus complex as summarized by Mullahy is that the expelled sons in the primal horde banded together, slew the expelling father, and then —in order to prevent themselves from destroying each other—erected an incest prohibition. For Fromm, the Oedipus myth is not a symbol of incest but a symbol of the rebellion of the son against the authority of the father in the patriarchal society. For Horney, the Oedipus complex is not essentially a biological phenomenon but a problem arising out of describable conditions in the family. Attachment to parents is "but a response to provocations from the outside." For Sullivan the Oedipus complex arises from the fact that the parent of the same sex feels more familiar with the child and hence can assume an authoritarian attitude, thus producing resentment and hostility in the child.

The chapter on Horney and Mullahy's critical evaluation of her writings in the concluding chapter are disappointing. Mullahy has focused rather excessively on her earlier works and has not given enough space to

Our Inner Conflicts. As a result, he does not impart a comprehensive account of her theory of neurosis although a skeleton outline is discernible. In discussing character versus situation neurosis he quotes Horney's definition of the latter from page 30 of *The Neurotic Personality of Our Time* and states that "no example (of a situation neurosis) is given." It is true that no example is given on that particular page but a cursory glance at the index would have provided Mullahy with an excellent example of one on page 90.

In his concluding chapter, he finds a "formal" contradiction in Horney regarding the question of the basic conflict arising out of the existence of incompatible attitudes. What troubles Mullahy is that "the three attitudes enter in as, or contribute towards, major attempts at solution of the basic conflict. This then, implies that the basic conflict is prior to the incompatible attitudes." The confusion can be dispelled by stating that the incompatible attitudes as such do not contribute to the solution of the basic conflict. It is what the individual does with the attitudes—repressing two of them and bringing into prominence and adopting as a way of life the third—that Horney designates as one of four attempts at solution. Peculiarly enough, Mullahy listed this particular attempt at solution in his chapter on Horney.

His treatment of the other writers is, on the whole, fair and sympathetic. He has abstracted from Rank's very difficult works a very plausible statement of that author's theory of individuality and autonomous will, pointing out that the main step toward attaining individuality is separation. At first it is physical separation from the mother but ultimately from various forms of psychological dependence.

A serious defect in the book is the fact that only one chapter is devoted to critical appraisal. As a result, there is engendered in the reader the impression that what Mullahy has said in the body of the work is unqualifiedly accepted. In only one chapter was there any exception taken by Mullahy to anything that was quoted—the chapter on Rank where a justified attack on Rank's unscientific ideas of truth is made.

A minor flaw in the work is the lack of an index. This is only partly compensated for by a fairly exhaustive breakdown of his material in the table of contents. Despite these shortcomings, the volume should prove extremely valuable to all who are interested in psychoanalysis, particularly beginners in the field, to whom it will prove useful in their reading courses.

—Abe Pinsky, M. D.

Power and Personality. By Harold Dwight Lasswell, Ph.D. 262 pp. 1948. W. W. Norton. $3.

In *Power and Personality* Professor Lasswell has brought together his Salmon Memorial Lectures. He has undertaken a huge and very important task—the task of finding ways of implementing the development of democratic leadership. The trends of the times, the emergence of newer and more efficient ways of being destructive make such work necessary and immediately imperative. Any voice, no matter how it speaks—so long as it speaks the cause of human dignity—is of momentous importance. Dr. Lasswell's book does this eloquently and more. For he not only offers many positive ways of making the democratic way workable, but he also raises many more issues than he answers. In this way his book becomes a highly provocative work, which is the spirit that must obtain if democracy is to be kept alive. Democracy is not a state of being but a process which must be eternally nurtured if it is to be had at all. This spirit pervades the book. It is a piece of living democracy in the reading.

In approaching the problem the author makes use of historical as well as of present-day data to demonstrate how all the data may be re-evaluated in the light of recent advances in the social, psychological, and medical sciences. Although his interest is in the relationships between the elected and the electorate, the empowered and the empowering, he also focuses upon the problem of the self. He regards the self as including "more than the primary ego," referring to his irreducible "I," "me." "The self takes in whatever is included with the primary ego as belonging with it." The boundaries of this self include, in addition to the primary ego, sym-

bols which refer to parents, wife, children, countrymen, etc. "The personality includes demands made by the self on the primary ego and on each constituent part of the self." Of central importance is the postulate that the self is concerned with overcoming deprivations of all sorts. Thus the power-seeker seeks power as a means of "compensation against deprivation." Since it is the power-seeker who will place himself in the position of holding office, in whatever capacity, it is towards this "type" that all attention is diverted.

With this as his thesis, numerous examples are cited to show the variations in history as a result of alterations in the pattern of "deprivations and indulgences." Part of the thesis has it that the parents are of primary importance in inculcating ambition in the offspring, who in turn will use it to compensate for deprivations in later life. The problem is one of balancing indulgence and deprivation. Although some weight is placed upon the existence and operation of unconscious forces, it is felt that these are not sufficiently emphasized or utilized in understanding the contradictions that may operate in the human being. Also, little emphasis is placed on the use of power as a neurotic solution in the sense of being compulsively determined. Rather he regards power-seekers as being impaired by neurotic processes. Not clearly demonstrated is any difference between (1) power-positions arrived at because of unconsciously motivated and compulsively determined operations and (2) wholehearted and constructive engagement in power situations.

He clearly delineates the democratic character structure according to such ideas as postulated by the late Harry S. Sullivan: that is, that such a structure cannot develop unless that individual esteems himself enough to be able to esteem others. This "positive indulgence" the newly born must receive from the human environment. He further feels that it is because of this early life indulgence that certain individuals possess the basis for the extraordinary capacity to remain warm, generous, enduring, hopeful, and spontaneous when others project blame, dash themselves to pieces, or retire "tracking clouds of regressive fantasy."

He endeavors to explain malformation of democratic character on the basis of what he calls the "social-anxiety hypothesis." It states that basic character formation is a junction of inter-personal relationships. Poor formations in character result from such interpersonal relationships in which "low estimates of the self are permitted to develop." It further postulates that "the devaluation of the self is in terms of the evaluations of other persons." Further, the result is "many defense reactions running a range from hopeless acquiescence to reaction formations and other compensatory devices." However, and in keeping with what is believed to be an over-emphasis on the interpersonal aspect of human relatedness, this hypothesis places insufficient weight on the forces which are generated in the course of the evaluation of the damaged human being—forces which generate intra-psychically. Since the emphasis is on the inter-personal the tendency seems to be to over-emphasize the importance of external factors in this process. Now, in keeping with the latest advances in understanding the importance of the intra-psychic, as demonstrated in the Horney theory of neurosis, such a position carries with it a pessimistic and mechanistic stand. For if the individual is a mere tool of such external forces and exists simply to change from one form into another—a pattern which was laid down for him and continues to be laid for him as a result of interpersonal aspirations—then such a person will be deprived of any opportunity to develop an autonomous self. In other words, unless the center of the self is placed within the individual, be it neurotic or psychotic, no possibility can be entertained of effecting any change either within the individual or in the society of which he is, *sine qua non*, its true representative. Without such a state of affairs, the chances of developing a free individual—free in the sense of being free of forces which all unaware to him determine his activity—are greatly reduced. There is an economic principle involved here also, for the chances of utilizing natural forces in a directed and concerted manner are much reduced if the unit of force lies between individuals rather than within them. One might mention such important concepts as the pride-contempt

systems—wholly intra-psychic evolvements —which play such important roles in the totality of the process of living. This process could be complicated manifold by the introduction of such important processes as externalization—upon which, it is felt, the author places insufficient attention.

From this sampling it may be sufficiently apparent how many issues of a controversial and alive nature are raised. A stand is taken for the operation of what the author calls "social self observatories." These are compared to other kinds of observatories which house astronomers, etc. While society does provide for a kind of social self observation in terms of price tabulations, imports, exports, birth, mortality, etc., he would set up observatories to operate in all strata of society, all cultures, in order to obtain adequate samplings of the effect of institutions on "character-personality structure." One aim of such a procedure is to reduce "much current confusion of usage and sectarianism of observational procedure." All this is with a view of "exposing the truth about the hidden destructiveness of our cultural institutions and of reporting on the effect of experimental efforts at reformation."

In an appendix to the book, numerous definitions are set forth in an attempt to lay down general principles for purposes of clearer communication. Of special interest are tables of the interaction results of various values upon each other.

This is a work of importance, for in bringing together all the major fields of social endeavor, the fact of their inter-relatedness is accentuated. Further, it helps to point out those areas where so much work urgently needs to be done.

—Louis E. DeRosis, M.D.

Sexual Behavior in the Human Male. By Alfred C. Kinsey, Wardell B. Pomeroy, and Clyde E. Martin. 804 pp. 1948. W. B. Saunders Company. $6.50

The publication of a report which gives statistical facts about the sexual behavior of 12,000 American men has two potentially constructive aspects. First, it may provide the psychiatrist and other scientists with unique material, rarely obtainable in such quantity. Secondly, this scientific report—the first to become a nationwide best seller —may contribute to a decrease of prejudice and an increase in tolerance, since it must undermine any idealized image fostered by some exponents of our culture concerning the realities of prevailing sexual patterns. It should lessen hypocrisy and condemnatory attitudes against deviants from the more common forms of sexual behavior.

However, such potentially constructive value is considerably diminished if the reported facts are open to misunderstanding and misinterpretation. What is the source of these facts? A highly elaborate interview method which deserves credit for eliminating many possibilities of error. But analytical experience has shown that one or several interviews, even though most skillfully conducted, can hardly produce reliable and comprehensive information about an individual's sexual life.

What are the facts on which the report is based? They consist in the statistical incidence of various forms of "sexual outlets," such as masturbation, homosexuality, and extramarital intercourse. In the light of character-analysis, which sees sexual behavior as determined by the total character structure and by the specific function which sex has in it, these facts are symptoms only. The frequency of these symptoms can by no means be taken as a criterion of their normality or abnormality. The authors' findings that more than ninety per cent of men masturbate, about thirty-seven per cent have some homosexual contacts, and about fifty per cent of all married men have extramarital relationships, do not give the character of normality to masturbation, homosexuality, or extramarital intercourse. They only reflect the effect of specific social and cultural conditions upon sexual behavior in our culture. What is frequent or even average in a certain culture is by no means necessarily normal or healthy. It may even indicate, and often does, that the cultural conditions which produce it are unhealthy. Kinsey is right to reject the labeling of a behavior pattern as abnormal or unnatural only because it is rare, but he commits a similar error when he equates "frequent" with "normal" or "natu-

ral"; or when he concludes from the relatively high incidence of occasional homosexual experiences that "homosexuality is an expression of capacities that are basic in the human animal."

The repeated attempt to interpret human behavior in analogy to "basic mammalian behavior" reflects another methodological limitation. This must inevitably lead to complete disregard for the role which varieties of sexual behavior have as expressions of interpersonal relationships. The severest mistake in Kinsey's method, however, is the use of the quantitative factor of the number of "sexual outlets" as the basis for conclusions about the character of sexual life. Far from being an unchangeable constitutional characteristic of the individual, this number only represents a symptom which may be caused by a variety of psychodynamic processes. Therefore the same figure may have a completely different meaning in different cases. Masturbation, for example, has entirely different meanings during adolescence, before marriage, and after marriage; as an emergency measure, or as a compulsive phenomenon. The meaning of a homosexual contact is certainly not the same in a single or rare experience during adolescence and in a lasting behavior pattern during later life. Homosexuality means least what it is assumed to mean in the Kinsey report: a constitutionally determined, primarily sexual phenomenon. It indicates an extreme alienation of the person from his real self and his sexual role, a severe fear or conflict connected with heterosexual contact.

Even the quantitative factor, as expressed in Kinsey's figures of "sexual outlets," is itself only a symptom—a symptom not of constitutional sexual endowment, but of the role which sex plays in the total character structure of the individual. A "low frequency" may be caused by very many entirely different factors, such as: fear or conflict connected with sex or with the "test situation" which the sexual act may represent; unconscious rejection of the partner or hostility against him; or the preference of living in imagination to the reality of sex. On the other hand, a "high frequency," which the Kinsey report seems to favor, does by no means always reflect a constitutionally strong sexual endowment, nor a high capacity for sexual enjoyment. The "high frequency" may be produced by the inner pressure of anxiety or by an over-emphasis on sex in neurotic persons for whom sex has become the carrier of compulsive needs, such as dependency, aggression, self-glorification, or attenuation of self-contempt.

Neither the frequency nor the character of the "sexual outlets" is constant in the individual. Both change even in the relatively short period of a character analysis. We must ask: What is the meaning of the sexual behavior? What are the dynamics behind this symptom? What are the psychological forces and conflicts which find their expression in the figures of "outlets?" Our real problem begins whre Kinsey's facts end.

—Frederick A. Weiss, M.D.

The Next Development in Man. By L. L. Whyte. 222 pp. 1948. Henry Holt and Co. $3.50.

Whyte prefaces his book with a discussion between Socrates and Cratylus in which the latter says, "However, I assure you, Socrates, that I have already considered the matter, and after toilsome consideration I think the doctrine of Heraclitus is much more likely to be true." To which Socrates answers, "Some other time, then, my friend, you will teach me, when you come back." The doctrine under consideration was the Heraclitean idea that change is universal and that in change there is a pervasive order. In a sense, Whyte has set out to be the spokesman for Cratylus and Heraclitus in his concept of the Unitary Man. And he returns to a world apparently more ready—through the development of knowledge and material conditions—to re-examine its meaning with dynamic concepts.

The post-war period, which has found the world even more deeply involved in conflict than during the shooting phase, has seen an exciting development in scholarly works directed toward a reappraisal of man and his history. In addition to the book under review, significant works are F. S. C. Northrop's *The Meeting of East and West;* Toynbee's *A Study of History;* Karl Lowith's

Meaning in History; the works of Albert Schweitzer. Implicit in this whole period is the conviction that things grow, that the past has meaning for the present, and that the future develops out of the present. Further, the premise is that change occurs in an ordered manner, that man can discover this order and can—through knowledge and as a part of nature himself—be active in facilitating changes.

L. L. Whyte is himself an example of the unitary man he writes about in that he is by profession a physicist who, searching for the meaning of man, has deeply involved himself in a study of the history of ideas and knowledge. *The Next Development in Man* is his effort to understand man and his universe, and through such understanding to take his place in history as an active participant. His thesis can be stated as follows: (1) There is a process in all of nature, and (2) This process is essentially unitary whether it be that of inorganic matter, physical forces, or organisms. In another way, Whyte speaks of a formative process which pervades all nature and which tends toward symmetry or perfection. Perfection of form is more closely approached in the case of inorganic development, but "organic development is a process of continuing adjustment." Whyte is not here referring to the mechanistic concept of adaptation or adjustment to static conditions of culture or the universe but is considering the process of development of man and his environment in its total dynamic interrelationship. Whyte further stresses this in his concept of "facilitation"—i.e., various forms which appear in the developmental process are themselves the foci for further development.

So far as man is concerned, Whyte believes that ideas facilitate the patterns of behavior to which they correspond. In our psychoanalytic concept, this is similar to the belief that man can live his own life and is in a large measure responsible for himself. It is this idea which leads Whyte to feel that his formulation of unitary thinking has the possibility of generating an entirely different practice in the world. As he sees it, man's knowledge, thinking methods, material conditions have reached a point where a unitary formulation, made clearly, will result in a wholesale recognition by people that this is what they are already thinking. By gaining such recognition, man will then facilitate his further progress toward unity. In other words, the world has already arrived at the brink of recognizing the unity in the differences, or to use Heraclitus' phrase, "permanence in flux," and now awaits the clarion call of a unitary formulation couched in a unitary language. There is a bounding optimism and a pervading sincerity in this book, a spirit which is necessary in one who would facilitate the reorientation of values the world so sorely needs today. Not to criticize the author, but rather to inject a note of caution, we must warn the reader lest Whyte's infectious optimism blind him to the retarding forces of vested interests and, in a personal way, to the pride-invested values. Such a consequence would make him a very ineffective facilitator of his and humanity's growth.

In his historical survey of various thinkers whose works contributed to the development of unitary thought, Whyte includes a section on Freud. Some of his comments here will serve to preface certain remarks regarding Horney's theory in relation to the unitary development. He gives deserved credit to Freud's pioneering and to his opening "a virgin field to knowledge" and developing a method which "could sometimes restore the neurotic to health." He says further, "But he did not know why his technique had that therapeutic power." He refers to the necessary limitation facing Freud because of his position in history and the consequent use of dualistic and static concepts. The following states clearly the defects of Freudian theory as seen by Whyte's unitary concept: "Freud's technique is successful when it sets free the *formative process* in the patient; his theories are inadequate . . . because the dissociated tradition working in Freud's own mind prevented his recognizing the formative process. . . . The technique often failed, because it left the patient without self-knowledge which is only possible through a unitary form of thought." And "Freud's world of thought lacked the formative principle which could set the spirit free to recover its sense of freedom within the necessity proper to itself."

We might well inquire what is the correspondence or lack of correspondence of our theory with Whyte's. There are numerous points of similarity between Horney's theory and unitary thought. There is first the dynamic quality which is embodied in the concept of process. Our concept of the neurotic character is that it is the form which is the consequence of process, and which is not itself a static structure but a stage in process. And perhaps the essential correspondence is that which relates to the formative principle. The recent formulations of Horney regarding the real Self, the repository of the energy for growth and creativity is in essence the formative principle of Whyte. According to Whyte: "What is needed is not a psychosomatic science which assumes the co-existence of psyche and soma, a mind and body, but a unitary method in which no basic dualism is admitted." In this regard, too, our theory and methodology correspond. The individual may express himself verbally, in dream symbols, in body posture and gestures, in more involved behavior, but he is always expressing an aspect of himself. While we may at one time or another stress a constructive or a retarding force, we are still referring to an aspect of a total person, more or less whole-hearted, more or less conflicted, but always involved in the process of actualizing himself.

In discussing the characteristics of man, Whyte brings out clearly the unitary conception as contrasted with the dualistic individual-environment dichotomy. His ideas are quite in accord with those developed in Horney's *Neurotic Personality of Our Time* in that a mutually interacting relationship obtains, rather than an inherent opposition. He recognizes that each individual has numerous aspects and potentialities. Among these are the tendencies toward immediate, spontaneous reactions to stimuli and also toward delayed, deliberate responses. The latter, a function of man's more complex brain and intellectual potential, made possible a greater control over the dangers of nature *and* over his more elemental, immediate, feeling responses. Through his greater control over nature's vagaries he was able to thrive and develop our present material civilization. However, the corresponding control over spontaneous behavior was not an unmixed blessing. As the civilization he built through intellect became the milieu in which the totipotential individual was nurtured, the high value placed on intellect and deliberate behavior facilitated the subjugation of the immediate, spontaneous part of the personality. The consequence was what Whyte calls the European Dissociation, which implies "disorganization of behavior, emotional conflict, and intellectual dualism." Thus man, using one aspect of himself—his intellect—for himself, created conditions which facilitated this development to a point where it became a force against himself—his spontaneity. And out of this high value placed on intellect, the individual has developed static concepts of perfection. Whyte states, "The ideal of perfection is an impostor; to claim it is to deny further growth." According to our theory, this is the situation which obtains when the individual invests some aspect of himself with pride, looks on his real, growing self with contempt, and essentially denies growth in favor of a static, timeless illusion of life—which is not living.

Whyte recognizes in this so-called dissociation of man, in his sacrifice of his wholeness for one aspect, the tragedy of modern man. But he goes beyond this in his optimistic belief that man can change and once more bring his whole self into the service of his organic possibilities, his growth and development bounded by the limitations of his nature. This is an optimistic book, a challenging and stimulating book in a direction which affirms as does our theory the truth of the constructive possibilities available in man.

—Norman Kelman, M.D.

SCIENTIFIC MEETINGS

Regular Meetings at the New York Academy of Medicine

SHALLOW LIVING AS A RESULT OF NEUROSIS. *(Karen Horney; Sept. 22, 1948)* The problem of shallow living first struck me when a writer consulted me as to why he had become completely unproductive after having written one quite good book. At that time I eliminated the possibility of conflicts about subject matter, then found progressively that he had greatly diminished interest in any subject at all, then began to see that he had turned entirely away from any serious work and had for years simply pursued pleasure. When I pointed out that he had turned wholly to the periphery of life and spent all his energies there, and that as a result all his feelings had flattened out, he was able to tackle this with real seriousness, get to work again and make some progress.

Later Erich Fromm wrote of this problem in individuals who had been crushed quite early in life—and who then started simply to adapt themselves, like automatons, never undertaking any life of their own. He made the point that this condition should be distinguished from a condition of "defect." Problems similar to this are described in Jackson's *The Outer Edges,* in which a brutal murder can be experienced by those around only as a sort of thrill, and in George Eliot's *Romola,* in which a slight weakness of character slowly develops into a real deterioration of the whole personality.

These examples show different parts of the same syndrome: A person who was originally normal, capable, full of life, later shows loss of moral values, of feelings, and of real appreciation of life. By definition, this is a kind of living that lacks depth and intensity; lacks direction, autonomy, and real meaning. This I would call shallow living.

Concerning feelings and interests, we can say that feelings in such people are very shallow. Words of praise or warmth appear easily with little meaning and no marked sincerity. They have personal conversations but no serious discussions, and they seek diversions more vigorously than anything else. Their interests are directed almost entirely to external values, such as money, entertainment, or gossip. Although they may talk of art, music, social questions or politics these talks are apt to develop more by contagion than spontaneous interest. They show failure to form judgments of their own and are influenced more by current opinion or by what others will think of them. Interest in their own growth and self-development is lacking and their talk of values is shallow. There is drifting because of few real convictions or serious direction of their own lives—which alone can steer and guide one's life.

One group is interested only in pleasure. One might call their theme, "Oh, give me a home where the millionaires roam," but it would be a mistake to think this refers only to the leisure classes. It is as true of those who go to the movies as of those who make up theater parties. It may also take special forms, such as collecting stamps, fancying oneself as a gourmet, or reading mystery

stories. These people will protest, "But it's so much fun being with people where nothing happens but drinking and talking." This can be quite deceptive. It may look like zestful living, freedom and broadmindedness, whereas it is nothing more than an escape into talking and lack of standards. What is called "doing the right thing" may cover deceptively a lack of real moral fibre. Then there are the opportunistic people, whose real goal is to avoid friction or pain and always to get by. Overlapping with this group are the prestige-seekers—prestige not through work but through being in the right group, with the right people, doing things likely to bring success.

In all these groups is a profound feeling of futility, although it is usually largely repressed. The prognosis for the individual is better if this feeling comes to the surface, because it indicates there is some capacity for seriousness still alive. Among all these people there is an aura of something impersonal, even in such intimate relations as marriage. There is little real investment of themselves in anything they do, and a very great overemphasis on external values.

Do such people come to analysts? Rather rarely, because they specialize in seeking easy methods and quick cures. The easier the life they have created for themselves, the less they will go into serious discussion of themselves. This kind of living is seen so frequently in modern societies that we tend scarcely to realize how unhealthy and unnatural it actually is. Further, the actual character of the problem is often obscured by the convincing externalizations offered by them: that their unhappiness comes from a wrong spouse, climate, or diet. It is typical of those who externalize a great deal that they tend to be so alienated from themselves as not to feel things as caused by themselves, but in general to look around the external world for explanations.

Some of these people are not wholly deadened, and a part of themselves may feel futile and distressed, while others become aware of disappointments and distress about themselves only as it is manifested in psychosomatic illnesses. If they come into analysis, they are prone to stop early upon relief of one symptom, or to find excuses for stopping abruptly when their values, standards, and goals start to look uncomfortably clear.

Erich Fromm has raised the question as to whether this is innate or acquired. In my own experience, the analytic data indicates that such patients have been much more alive around adolescence. They have had ambition, have wanted and acquired things, have had deep feelings of love or despair, or were real leaders in their groups. Then they went through some serious disappointment, despair, or depression, after which there was apparent recovery. Later they seemed duller and slid into a pattern of shallowness offered by the environment. For example, a New Englander may become quite bohemian, or perhaps go after only earning money, or become stuffily pompous. On the surface, they may then show a glib, smooth behavior, but in their dreams one will find depth of feeling, despair, hope, self-hate, anxiety. And in the course of analysis, in connection with some memory, something very alive will appear again, in which depth and intensity of feeling are shown to be really there.

But there is another factor which shows they are really present: There is an anxious moving away from the real self, from their real depth. When these appear in dreams and are pointed out, they move away from the dream. When they are brought back to it, they leave again and go on in an impervious manner to something quite far from it. There is a tenacity to this process which indicates the effectiveness of externalization as a way of letting nothing touch one. This is a deliberate moving away from life, toward the surface—not one turning-away but a continual one. This means that this movement must be of great value to them. If we remember the functions of the real self as an inner spring, as a source, a directing power, a judicial power which decides our values for us as a basis for our electing or rejecting, then we find a high degree of alienation from the real self in shallow living. If this is pointed out to the patient, he sees it but is not interested, or will reply that he feels what he is doing is all right and is a better way of living. Upon trying further and pointing out to the patient that he could make much more of his life and have much more

happiness, one meets complete failure. But it becomes clear then that this patient doesn't really expect anything. He is not hopeless, he just doesn't want to be pulled into any maelstrom. If he is more sophisticated, he may bring up something of oriental philosophy, or some sort of philosophy of seeking peace. But there is a determined resignation from active and productive living of his own life.

The leading role here is not the search for glory, because, although there is a definite idealized image, the resignation means the patient has actually given up active efforts to achieve anything in reality, in actual achievement. It is much like a person who can do good work, but settles for simple tasks because it is easier. Even the members of the prestige group, from whom one might expect more activity, have actually the same attitude. They look to gain not from real work but through association with others.

The most serious consequence occurs in their own lives, as a restriction on real achievement requiring active efforts. This may be very unsatisfactory and may be possible to change, but they do not see this. Instead, they evolve a kind of endless patience which is actually a neurotic resignation.

Often they can be quite active in helping others. They will then make many excuses for doing nothing for themselves. This is also resignation. They do not want friction, fight, or pain. They may call this compliance. It is not compliance but resignation, which is deeper. This neurotic resignation is a recoiling from inner struggles. Those who take this curious and fatal step choose it as a solution to keep from suffering too much from their own internal conflicts. By this means they find a certain kind of peace. If they resent any fighting, it is because they have given up and recoiled from any inner struggle. The external struggle is only an extension of the internal ones.

But there can be other outcomes. There may be a profound inertia as a cover for inner resignation, or an enormous restriction of activity as a consequence of resignation. A still further step may be the feeling of not wanting anything at all for one's self—that is, eliminating one's self entirely, with an attempt to live wholly for others. This is sometimes fairly successful and satisfying for a while and such a patient is apt to come to our attention only when this solution has broken down. If we look on this condition as a result of an active neurotic process, then the outlook is quite hopeful compared to regarding it as an innate or hereditary defect.

Analysis of such patients may end unsatisfactorily because of unrecognized resignation, in an open or hidden form. This needs to be recognized and tackled quite early and can never be lost sight of. This tackling is particularly difficult because the patient is so averse to pain, efforts, and change in general. He has found peace of a sort, and he doesn't want to risk changing from these narrow confines. The success of analytic work will depend on the amount of constructive interest still alive in the patient.

I selected this subject as an opportunity to discuss resignation as a destructive force of the first magnitude, then secondly because this syndrome occurs so frequently in modern civilization. It is even more apparent that this condition cannot be innate, since it is so widespread among intelligent and able people and involves such serious loss.

It is interesting to speculate to what extent cultural factors may be involved in its occurrence. Sociologists could undoubtedly produce evidence of this. For individuals, however, these social factors are less important. The individual needs to come out of this crippling condition, then be prepared to help others to free themselves from it. He must also be prepared to work through the personal factors in himself, rather than look to the culture for an understanding of it.

Social approval of this kind of living makes it more difficult for people to see that there is anything pathological in it and makes it harder for psychiatrists to work against it. The clearer the psychiatrist understands the dynamics of it, the better will he be equipped to deal with it.

CONSTRUCTIVE FORCES IN DREAMS. *(Frederick A. Weiss; Oct. 27, 1948)* Published in this issue.

REASSURANCE IN THERAPY. *(A. R. Martin; Nov. 24, 1948)* Published in this issue.

NEUROTIC GUILT AND HEALTHY MORAL JUDGMENT. *(Muriel Ivimey; Jan. 26, 1949)* Published in this issue.

THE PROCESS OF SYMBOLIZATION. *(Harold Kelman; Feb. 25, 1949)* A symbol both indicates and represents something else. It is not a substitute for a particular object, but a vehicle for the conception of an object. Thus, a subject or person is required to whom the representation means something. Symbolization is a mental process which transforms stimuli from without the body or from within into symbols having meaning for the individual.

Psychological contents function as symbols and psychological processes are operations with symbols. For example: A woman comes into my office with a cheery "Good morning," adds "It's a beautiful day," and says, "My husband will receive a promotion. I'm so pleased and we are planning on that winter cruise." What she said were psychological contents, but each word was a symbol of what she was thinking, feeling, and doing. The psychological processes going on within her determined what she was doing with these symbols. She did not limit herself to verbal symbols, however. There were other symbols: her gait, her smile, her tone of voice, her dress. There were visual mental images: pictures of Bermuda when she was last there. There were perceptual images such as her own awareness of a beautiful day outside. Thus, this woman was engaging in psychological activity or symbolizing, which meant she was perceiving, feeling, thinking, imagining, and conceptualizing.

Imagination is the formation of mental images of objects not present to the senses. An image is a symbol, and imagination is the process of symbolization which is the formation of mental images. Only through imagination can an individual become conscious of his past, his future, and even his present. Subjective feelings cannot become conscious as such in an objectified sense.

Awareness is a broad experience which includes consciousness or imagination, and even more. Consciousness is not a static, circumscribed thing, but it may be considered synonymous with imagination. It is a sequence of mental images which we are having consciously. A person can have an image of himself and his environment only through his imagination.

The image anyone has of himself and the world may be more or less rational. That which is in proper ratio is rational. The poorer a person's relations are to himself and the world the more irrational will be his image of himself and the world. Also, the only picture he has of himself and the world is the one existing in the imagination, which may be more or less rational in comparison to the world as it actually is. Thus, everyone's image of themselves in the world has rational and irrational aspects.

The idealized image is a *gestalt* of images containing irrational aspects. The analyst observes the patient, collects his symbolic productions, and infers from all these over a period of time what is irrational and idealized in the patient's picture of himself in the world. Then the patient is helped to the awareness that aspects of his image of himself in the world are not in conformity with the actual situation.

In the process of living or of integrating, the individual is always symbolizing but there are sources of error. These have to do with the raw experience data, the inability of feelings to be objectified as such in consciousness, defects of memory, and selection of the material to reach consciousness. These errors result in irrational symbol formation. There are sources of error when a person distorts the evidence of stimuli coming from without the organism. This may be done by omitting or selecting parts of what is seen or heard. Further error ensues when inferences are made from symbols selected out of context because of subjective needs. The errors are reinforced when the individual does not check against reality.

Imagining, or the process of having images consciously, is an aspect of the process of remolding the reality of ourselves and our environment. Imagination can be used for creative pleasure, for pure enjoyment, and for constructive work as in analysis. Everyone has more or less the capacity for imagining constructively and in a constructive direction.

When one's imagining produces irrational symbols, when one is in improper ratio to

the reality of himself and his environment, he operates on the premise of the omnipotence of thought and the magic of language. Wishing means the magical powers of believing, deciding, and thinking. It may reside within the person or be externalized to a helper. The type of magic power varies with the individual's basic orientation to life. The neurotic takes what he should be as immediately accomplished and hence an actuality. On this basis, he may make fantastic claims.

Because the neurotic operates on the premises of omnipotence, he is a law unto himself, and reality is as he believes, thinks, or decides it. Such reality factors as time, space, gravity, direction, and the laws of human nature have special meanings for the neurotic which are not consistent with actuality. Such a person may have claims for immunity from fatigue, illness, aging, and weather changes. There are countless ways in which the person who lives in imagination—i.e., out of proper ratio with reality—disregards reality.

He feels he is immune to the laws of cause and effect, which result in great difficulties in human relations. He gets into difficulty because he imagines the effects of his thoughts, feelings, and actions will be exactly as he wishes them to be. The neurotic does not check with reality, and his attitude towards evidence may be one of disregard, contempt, and aversion. This may be a serious problem in analysis, where the patient may resist and discard evidence.

The neurotic's operations with images are neither fantastic nor meaningless, but are strictly logical within the framework of his total life experience if we accept his premises. This also holds in attempting to understand the meaning of dreams. People who live very much in imagination frequently confuse imagination with reality to such an extent that they do not know whether they have mentioned certain facts or have omitted to mention certain things, so that they are constantly making false assumptions. Such difficulties derive from the person's inability to check with reality.

The healthy use of imagining is motivated by genuine joy, fear, anger, sadness; the direction is wholly towards self-actualization with an emphasis on becoming. With the neurotic, the motivations for imagining are basic anxiety, basic hostility, neurotic optimism, and neurotic pessimism. The emphasis is here on being (safety), with much less energy left for becoming (constructive growth). Healthy imagining is connected with what is real in a person. The neurotic operates away from and against his real self (self-alienation). His neurotic character structure, a protective device, functions at the expense of his real self and stands between what is real in a person and in his environment.

He must always be on guard against the obtrusion of reality from within or without. In analysis, the patient is moving constructively toward reality. Sudden or even slight juxtapositions of reality and imagination can have a disturbing effect and may result in diverse symptoms or reactions.

MEDICAL PROBLEMS IN PSYCHOANALYSIS—THE INTERNIST'S VIEWPOINT. *(Gary Zucker; Mar. 23, 1949)* Published in this issue.

CHILD ANALYSIS AND HORNEY THEORY. *(Norman Kelman; April 27, 1949)* Published in this issue.

Interval Meetings at the American Institute for Psychoanalysis

THE VALIDITY OF DREAM INTERPRETATION *(Harold Kelman; Nov. 21, 1948)* Definitions are given of validity, plausibility, possibility, and probability. That which is valid is founded on truth or fact, capable of being justified, supported, or defended, well-grounded and sound. To be plausible is to be superficially fair, reasonable, or valuable; superficially worthy of belief, or credible. Possibility is within the powers of performance, attainment, or conception of an agent or activity expressed or implied; it is that which is not contrary to the nature of things, but which may, given the proper conditions, exist or occur. Something probable has more evidence for than against it and is supported by evidence strong enough to establish presumption but not proof of its truth.

The validity of a dream interpretation is predetermined by the validity of the theory

of human motivation from which it is evolved. A theory of man is valid the more it approximates and makes possible man's actualization of humanly possible ideals. Its validity is also relative to its ability to give a closer approximation to a picture of the reality of the true nature of man. The second predetermination for the validity of a dream interpretation is the reality of the data about the person concerned—i.e. a more meaningful, comprehensive, and unitary picture of that person. The third predetermining factor is the immediate data on the basis of which the interpretation was made. The analyst would feel that his interpretation establishes a clear connection with a problem recently or remotely discussed, and that it will aid in its clarification. Since all three preconditions are relatively valid, the validity of the interpretation can be only a relative one.

There are two categories of confirmatory criteria for the validity of an interpretation: the immediate and the ultimate. Either of these may be explicit or implicit. The immediate, explicit corroboration can be in the patient's reaction to an interpretation. The patient may say that it clicks and connect the interpretation with a problem past or present or with another dream. Immediate corroboration of the interpretation may be given implicitly. The patient thinks it sounds likely and goes on to further constructive work on the same problem. Or he feels less tense or has lost some psychosomatic symptoms after an interpretation. Interpretations may also lead to anxiety, psychosomatic reactions, irritability, or depression. These are not reliable corroborations of the validity of an interpretation. The ultimate explicit corroboration for an interpretation may be given by the patient later in the analysis when he becomes aware that the interpretation now has real meaning for him. He may ultimately imply that an interpretation was correct by declaring that the problem to which the interpretation was related became clearer, by a change or improvement in himself in relation to other problems or to the analyst, and by reorientations in values.

The analyst has criteria for the validity of his interpretation even when his patient cannot be of explicit help to him. These may be in the immediate sequences following his interpretation in the form of associative material, reactions of anxiety or hostility, somatic symptoms, a new dream, a new problem. Blockages may become less or greater. The analyst may also check the validity of his interpretations with certain ultimate findings. The problem discussed may have become clearer, may have diminished, or disappeared. As a consequence of the interpretation, the patient may bring a new problem into focus, may present a new constructive solution, new stands, and some reorientation of values. He may show greater ability to work on dreams and a tendency to live less in imagination.

The optimal situation obtains in supporting the validity of an interpretation where both patient and analyst are co-operatively working together and both can offer immediate and ultimate explicit confirmatory evidence. Both would feel it clicks in a real sense and would go on to offer such corroborative evidence as connecting the interpretation with the problem under discussion, with the previous session, with the sequence of evolution of this problem in previous dreams and other material of previous sessions. Both would note the disappearance of feelings of anxiety or hostility or their somatic concomitants. On the other hand, a patient may become blank, anxious, or irritable as a result of a valid interpretation. When a co-operative relationship obtains between analyst and patient, both would note the clarification of an old problem, a new problem coming into focus, a new constructive force becoming evident, a change of values with some significant stands taken.

Thus the list of criteria for the validity of an interpretation includes the preconditions and the immediate as well as ultimate corroborative evidence. However, we can only be relatively certain about the validity of an interpretation, or we may have to be satisfied with various degrees of probability. There can be no exactly right interpretation, for the same dream might be interpreted from several angles. The validity of a dream interpretation will become the greater the closer our three preconditions approach the reality of the truth regarding the nature of man and the nature of the particular man being analyzed. The possibility for greater

validity will increase as the analyst becomes a better analyst and the patient a more constructively co-operative patient.

REASSURANCE IN THERAPY. *(Nathan Freeman; Dec. 12, 1948)* This interval meeting was devoted to a discussion of Dr. Martin's paper published in this issue. The discussion was focused on reassurance in therapy as viewed within the framework of Horney's theory of neurosis. The neurotic character structure is composed of interrelated dynamic forces expressing defenses against disturbance to the defensive system. These defenses can be assailed by intrapsychic and environmental pressures. If they give way, the consequences are anxiety, fear, and terror. It is therefore not surprising that a neurotic individual seeks reassurance.

The broad definition of reassurance, "to free from terror, fear and anxiety," is incomplete as a general principle in psychoanalytic practice. We must take into consideration certain theoretical and practical factors which can affect the value or harm in giving reassurance. The therapist should be aware that at times reassurance can be useless or destructive and at other times valuable and constructive. Our theory differentiates between (1) retarding forces operating in the patient which tend to perpetuate neurotic defenses and irrational reactions, and (2) constructive forces which will enable the patient to work at his problems and which will tend toward a reduction of neurotic anxiety and other irrational reactions. The patient may seek reassurance therefore either in support of neurotic needs or in support of constructive interests.

Patients may seek reassurance for neurotic reasons in order to get signs of the therapist's affection, approval, or special care; or to perpetuate and reaffirm their belief in the idealized image; or to restore hurt pride. In order to get relief from self-hatred, they may express self-recriminations and guilt feelings in order to elicit reassurance from the therapist. If reassurance is given, it may relieve guilt feelings, but it is essentially useless if self-hatred continues unabated. A patient sometimes seeks reassurance by expressing self-recriminations in order to show the analyst how bad he (the patient) is and how easily the therapist has been taken in. This is a vindictive use of reassurance. In some patients reassurance is taken and used as a "should" in their strivings for perfection. A patient cannot accept or profit by reassurance (1) when he is living completely in imagination, i.e., when he is his idealized image; (2) during periods of intense self-contempt; (3) when he cannot tolerate any discussion of factors which are of supreme subjective value to him.

The conditions under which reassurance is of real constructive value are as follows:

(1) During periods of tension, anxiety or panic associated with real insights.

(2) When the patient is facing and experiencing actual inner conflict. Encouragement from the therapist helps the patient to endure anxiety and face his conflict. This leads to real solution of conflicts and permanent freedom from anxiety, rather than to allaying anxiety and the avoidance of conflicts.

(3) When the patient needs support of the real self as it emerges. Reassurance and encouragement can contribute to reduction of confusion which the patient experiences when he becomes aware of his real self.

In addition to specific constructive reassurance given at the appropriate time and in appropriate context, the therapist's interpretations, if well-timed and accurate, have reassurance value. They help the patient to understand himself, they set him thinking constructively, and they encourage him to participate fully in inner conflicts. Of reassurance value also are the therapist's voice, his equanimity, self-confidence, sincerity, empathy, and humaneness. The therapist's constant interest in the patient and his unwavering belief in the patient's capacity for growth is the cornerstone of the philosophy of Horney's concepts of human motivation. There is no blueprint to show exactly what to give in the way of reassurance or when and how to give it. It is up to the therapist's understanding, his experience and his own philosophy of human relations and life. Know your theory, be human, and have a heart.

AWARENESS OF CONFLICT. *(Alexander R. Martin; Jan. 16, 1949)* The embryologist A.

E. Coghill proved conclusively that integrated action or reaction of the whole organism always precedes action or reaction of its individual parts. Therefore the inner conflicts which beset all individuals in some degree, as a result of their upbringing, must always involve the whole organism. This total involvement in conflict can only be tolerated in full awareness if the conflicts are slight. Full awareness of total involvement in those gross, severe inner conflicts which originate through extreme malevolence and deprivation in childhood is an intolerable, anxiety-filled experience. To avoid this, a protective dissociation takes place by means of which the conflicts now reach awareness only in certain structural and/or temporal areas of functioning, while they continue to find expression subconsciously and unconsciously in other temporal and structural areas of functioning. In other words, there is a breaking up of total or global war into isolated battlefields. This is possible only by a lowering of the level of consciousness and at the expense of the patient's consciousness of wholeness and continuity. (Continuity is here seen as wholeness in a temporal sense.) In the structural area of living, spasm is seen as a somatic expression of conflict. Such dissociative processes provide a dynamic interpretation of psychosomatic disorders of a spasmogenic nature such as asthma, migraine, hay fever, coronary thrombosis, spastic colon, and the spastic conditions accompanying duodenal ulcer. Notice is taken of the increase of these spasmogenic conditions in modern life, particularly coronary thrombosis and duodenal ulcer. Substantiation of this whole hypothesis is found in the fact that these spasmogenic conditions frequently alternate with serious psychic disturbances, such as depression, depersonalization, and feelings of unreality.

If we accept this hypothesis, it becomes the function of psychoanalytic therapy to assist the individual to become aware of his total involvement in conflict. Emphasis is placed upon the recall of conflict rather than the recall of unpleasant incidents. Therapy does not consist only in making the patient aware of his conflict with the personal or impersonal environment, or with the analyst, but aware of the conflicting feelings and impulses towards the analyst and how these involve every aspect of his structural and temporal being, e.g. conflicting tendencies to defer and to defy, or the conflict between self-effacement and self-effulgence. Every dissociation of conflict brings with it a loss of a sense of wholeness and a consequent feeling of weakness. To help the patient become aware of conflict in any structural or temporal area of his being will bring with it a quantum of wholeness and strength and thus a lucky circle is started.

These speculations about conflict and the idea of total participation in conflict help us to get a better understanding of how a patient gains *real* insight as distinct from intellectual insight, and help to explain what really happens when a patient emerges from a marked emotional reaction (laughing, crying, the so-called "abreaction") with strength and greater insight. We have to differentiate between visceral participation in emotion and visceral participation in conflict of emotions. In the latter, there is a disproportionate reaction, an over-reaction. Similarly, we have to differentiate between total participation in emotions and total participation in conflicting emotions. In the latter, for instance, we have simultaneous laughing and crying, the so-called hysterical outbursts which frequently accompany feelings of insight. These emotions that accompany real insight can be the feeling of total involvement in mixed feelings, the simultaneous laughing and crying. The so-called oceanic feeling, or the "ah-ha" feeling of Freud, are all suggestive of a total participation or involvement in conflict. In describing the feelings that accompany this experience, patients talk of how deeply they feel; they speak of "the inside being torn out of me." One patient said, "It just wracked my whole body." It certainly seemed from the picture and from the content of these patients that they were greatly involved in conflicts at the moment of new insight. We have always recognized that the goal of therapy is to help the patient to be aware of his conflicts. He has to become aware of how they affect his life, their determinants and derivatives. But what is of greatest importance, he must see how these same conflicts express themselves

in dissociated structural and temporal parts of his life—e.g., at the somatic level, in the sexual life, business life, social life, intellectual life, in his childhood, in his dreams, and particularly in his life with the analyst.

What we do in making the individual conscious of his total involvement in conflict is to facilitate and bring all these different dissociated expressions of the same conflict together, so that instead of fighting out the same conflict in different areas and in different levels of functioning, he engages and participates in his conflict as a whole. The turmoil and agony that results is compensated for by the feeling of wholeness and wholeheartedness. There is a feeling of strength and a feeling of being superior and greater than the conflicts that are now in full consciousness. The total participation in the conflict and having it totally felt does not throw him. He no longer reacts to it, but he is able to take a stand and be active, rather than reactive.

The ability to withstand and experience conflicts totally within one's self has something to do with the ability to participate wholeheartedly and constructively in external conflicts. The wholeheartedness that comes with the admission into full consciousness of internal conflicts gives us simultaneously the capacity to enter into the external conflict actively and not reactively.

From a prophylactic, or health-promotion standpoint, it is most important for us to consider how we are preparing ourselves and our children to go out and meet life—that is, for wholehearted, active participation in the conflicting, incompatible, inconsistent behavior of human beings that constantly assails us.

A study of all evolutionary forms will show that superiority and survival vary directly with the length of dependence on parents. Certainly, in the last half-century, the period of dependence upon parents has gradually extended. This longer period of supportive and protective dependence provides the opportunity to prepare the coming generation. We must make better use of this longer period, so that we prepare our children to be aware of the contradictions, inconsistencies, hypocrisies, and conflicts, prepare them to participate and become healthily and not compulsively involved. Analysis provides a period of healthy dependency, which can substitute for the unhealthy dependency experienced in relation to the parents, during which the patient gradually gains the strength to admit into consciousness his total involvement in conflict.

There are cultural factors facilitating the individual's total participation in conflict. That is, the culture has developed ways and means of presenting the incongruities, contrasts, and conflicts of life in ways that are acceptable. For example, note the greater expressions of conflicts, contradictions, and inconsistencies in modern drama, modern music, modern art, and modern dance. Especially note in modern music the broken rhythm and dissonance. We see here some therapeutic value in that through this there is opportunity to participate totally in these conflicts.

We also see in this connection the therapeutic value of satire and certain forms of humor, by means of which we are either gradually or suddenly confronted with the incongruities, contradictions, inconsistencies for which we are not prepared. We are thus again encouraged to participate in conflicts. The ability to laugh at one's self, or to laugh at these representations of ourselves, particularly the representations that reveal our contradictions, has long been known as a safeguard against serious neurosis. It is not so much holding the mirror up to our shortcomings, limitations, and pettiness, but rather holding the mirror up to our gross contradictions. There is the juxtaposition of extreme opposites. This is the "arsenic and old lace" type of humor. The incapacity or inability to be sensually affected by these contradictory representations of ourselves is an indication of an incapacity for allowing ourselves totally to participate in conflict. There is something to be said for the so-called belly laugh as an indication of relative security and a capacity to participate totally in conflicts.

The paper concludes with some remarks about the positive gains from participation in conflict. Here it is necessary to think of conflict in a rather positive sense, as somewhat akin to friction. A recognition, or a realization of the uniqueness of individuals

brings with it an acceptance of difference, which becomes the basis of healthy friction. Inter-personal friction, which is the case with friction in the mechanical world, can be seen as the source of heat, light and power and provides the spark of life. In the healthy dependency period of childhood and the healthy dependency of analysis, there should be the opportunity for total participation in this healthy friction. The child who is loved and gets real affection does not withdraw, nor is he withheld from this healthy friction of life. We must differentiate between the healthy friction that naturally occurs on contact between unique individuals and is strength-giving and a means to a still greater orchestration of life —to differentiate this from the acquired unhealthy friction that develops between individuals who are anxiety-driven.

Body and mind are integrated and not antagonistic. What the individual tries to prevent by dissociation is the merging of body and mind in the same conflicts—that is, consciousness of his total involvement in severe conflict. The shift of the manifest expression of conflict from one sphere of functioning to another has been recognized by most observers, but it seems that the implications and significance of these shifts are quite obscure. All of us are interested in what brings about these shifts or dissociations and which have the more favorable prognostic significance. Is the shift from the mental sphere to the somatic sphere the one to be desired? The holistic approach should be followed. According to this, the organism's natural tendency is always towards wider and greater integration, orchestration and wholeness, which can be disturbed by severe acquired conflicts. The aim in mental hygiene and in psychoanalysis is to improve the capacity of the individual to accept consciously his total participation in all conflicts. A study of the neurotic individual's various efforts towards this total participation would give us considerable insight into psychopathological dynamics which, of course, includes psychosomatic dynamics.

THE UNCONSCIOUS. *(Muriel Ivimey; Feb. 13, 1949)* An attempt was made to clarify the concept of the unconscious by comparing what it meant to Freud and what it means according to concepts in Horney's theory of neurosis. In *New Introductory Lectures on Psychoanalysis,* Freud says: "The oldest and best meaning of the word unconscious is a descriptive one: any mental process the existence of which we are obliged to assume—because we infer it in some way from its effect—but of which we are not directly aware.... We call a process unconscious when we assume it was active at a certain time, although at that time we knew nothing about it." Elsewhere he says, concerning the relation between what is unconscious and neurotic manifestations, that Breuer's discovery of the disappearance of the symptom when unconscious processes are made conscious establishes a principle in therapy which is the foundation of psychoanalysis.

This original concept and its practical implications is clear and satisfactory. However, in his subsequent work it became more and more qualified by the systematization to which his thinking was subject. His concept of the unconscious became involved in purely figurative ideas and theoretical considerations. It took on a topography, it became a region or a province and then a system. Finally he said, we will drop the idea of a system and give it a different and better name. Groddeck suggested as a more suitable name a term originally used by Nietzsche: the id. From this point on the concept and the terminology became confusing, difficult to follow, and remote from the original clear and useful concept.

Freud's elaborations and schematization left us with a tool that is too cumbersome and unnecessarily complicated with attachments and accessories. He tended to split it off from the original concept as a whole —that unconscious processes contain the meaning of manifest neurotic behavior, thinking, activities, that they were the invisible motivating factors, and that re-establishing these connections is an essential process in therapy.

As to our concepts, we would start with the original concept as a whole. We would keep in mind the practical issue of the patient's not knowing, his unawareness, his ignorance of what is going on in himself which is compelling him to feel and think

and act as he does and of contradictory and incompatible elements in himself. In neurosis there is an absence of connection between his conduct and his inner feelings, his inner concepts of himself and others, his inner reasons, logic, purposes, and aims. Practically, our function is to establish these connections, to enable the patient to recognize and understand himself. This is in order that his problems come within range of his capacity to reflect, to know what he wants to do with his life, what he wants to be, rather than what he is forced to do and be.

Our working hypothesis is that there is a precise correlation between the manifest and the unconscious. In each individual patient this correlation is something to be discovered, starting with tentative interpretations of unconscious connections and going on to greater and greater precision as evidence guides us to true connections between the manifest and unconscious motivations. We would not assume that despite the fact that we never could establish a connection with some unconscious wish or interest which theory presupposes, that the unconscious wish must nevertheless be there. But we would stick to *evidence* of unconscious processes as revealed through the various avenues of expression. In that way, theory does not become static and dogmatic but remains subject to change and improvement.

We would not agree with Freud that unconscious processes generally are chaotic, but we conceive of them in a dynamic organization, separate processes representing elements in the neurotic character structure. This dynamic organization is subject to disturbance when a feeling of chaos is experienced by the patient, as in states of confusion, panic, fears of going to pieces.

In our work at problems in therapy, according to our concepts of the nature of therapeutic changes, we have observed unconscious processes characterized by interests in rationality; going forward toward health; impulses to grasp, retain, and work over ideas, values, solutions of problems that would be remedial and constructive. For these reasons, we recognize constructive forces and processes also operating without conscious awareness of the individual.

The term "the unconscious," with the implications inherent in Freud's thinking, is a misnomer in our frame of reference. We express our meaning if we use the word as an adjective—unconscious processes, unconscious forces, unconscious motivations, unconscious pride, hatred, destructiveness, resignation, self-effacement, etc. It is especially important to keep the concept connected with the specific significance and value it has as providing meanings for neurotic manifestations and their understanding.

MAN AS A THINKING MACHINE. *(Karen Horney; Mar. 13, 1949)* We find in many neuroses something in the nature of an elaborate philosophical system. One such system is founded on the belief in the power of the mind in which an enormous pride is invested. Thinking then takes on special importance since it is used in the service of the neurotic pride system as distinguished from the service of healthy and constructive purposes. Those who invest thinking with neurotic pride tend to talk endlessly and will intellectualize everything without any involvement of their true feelings or their true beliefs.

Thinking powers are used to promote a kind of self-idealization in which the belief in the supremacy of the mind and compulsive efforts to mold oneself into intellectual perfection are prominent features. This is seen most frequently in aggressive individuals. It is accompanied by marked alienation from themselves and little awareness of anything else about themselves, their feelings, or their bodies. In vindictive individuals feelings are undervalued and disparaged. Such people end by having nothing to live for except their minds. With this comes a kind of retirement into the intellect, detachment from others, and a high degree of alienation from the self.

They may be quite dead emotionally, and they often feel lucid and clear only when they think or read. They frequently say, "I have no existence apart from my thoughts." Intellect is used as their only standard for gauging superiority, and they expect and require themselves to be supreme in that area. Any failure to achieve that is regarded as total failure at the moment and in life in

general. The intellect is used in the service of power over others—outwitting, outmaneuvering, and confusing others by complicated language which, frequently, no one can understand. Sadism is always present. They size up others in respect to intellectuality exclusively. They prefer highbrow talk and evaluate others according to their capacity for this kind of talk in a spirit of competition and disparagement. They try to maintain a Godlike self-sufficiency because of the inner dire necessity to confirm the idealized image and the pride system. They need to regard their own thinking as infallible. Since they have nothing else, their lives—apart from intellectualizing—are usually quite barren.

What does this do to the individual's attitudes toward himself? He loses respect for himself as he really is. He cultivates a passion for getting by, or getting around everything quickly. In analytic treatment, wanting to get by may be a serious retarding force. When a patient sees a conflict, he at once asks: "How do I get over it?" which stalls him in actually working at a problem. In addition to wanting to get by, he also takes pride in getting by very fast.

Pride in intellect has a constricting effect on the ability to enjoy anything, since nothing can be enjoyed that hasn't been approved by the intellect. Is it rational, does it measure up, is it perfectly acceptable to my thinking? Only if it passes can it be enjoyed.

The opposite is found in the self-effacing person who feels he never thinks as well as others do, never has any ideas, and quickly calls himself stupid. There is an anxious need to make no claims to having a good mind, in order to avoid disappointments.

Intelligence can be turned wholly to the service of neurotic pride, rather than toward enriching life and the enjoyment of being wholly one's real self. In other cases beauty or sex can likewise be turned to the service of pride with the same consequences. Analysis would aim to achieve synthesis with the real self as a whole, using knowledge not just for pride in knowledge but for understanding and in order to increase the appreciation and enjoyment of oneself and others.

FINDING THE REAL SELF—AND ITS SIGNIFICANCE IN THERAPY. *(Karen Horney, moderator; April 10, 1949)* Presentation of the letter published in this issue.

FINDING THE REAL SELF—AND ITS SIGNIFICANCE IN THERAPY. *(Karen Horney, moderator; May 15, 1949)* Discussion of the concept of the "Real Self." Amplification of this material will be published in subsequent issues of the JOURNAL.

ANNUAL REPORTS: 1948—1949

The Association for the Advancement of Psychoanalysis

The past year has contained many evidences of the Association's growth and expansion. In December, 1948, the Association, ACAAP, and the Institute moved to new and more spacious quarters at 220 West 98th Street. The number of analysts certified by the Institute and admitted to the Association as associate members has increased threefold over the previous year. A candidate of the Institute has presented an original paper at an Academy meeting. The number of candidates who have been first and secondary discussants at these meetings has greatly increased. At the Association Interval meetings one candidate presented a paper, a number have functioned as moderators, and the participation in the general discussion by the candidates has been much broader.

This year the Association made a significant step in the direction of greater participation in the activities of the American Psychiatric Association. Dr. Martin has been made chairman of their Committee on Leisure-Time Activities. At the Annual Convention held in Montreal, Canada, from May 23 through May 27, 1949, there were 15 members of the Association and candidates of the Institute present. Dr. Horney presented a paper entitled "Dynamics of Psychotherapy" which was heard by over 700 people. Representatives of the Association discussed 17 different papers given during the convention. In addition the viewpoint of the Association was presented to many others through innumerable personal contacts. On the basis of this very satisfying and effective effort, plans have already been initiated for an even greater participation at the next annual convention to be held in Detroit, Michigan, in May, 1950.

With all these expanded activities, the Association continues to carry on its other regular functions: the publication of the AMERICAN JOURNAL OF PSYCHOANALYSIS, the direction of the community-education program carried out by the Auxiliary Council, and the operation of the Association Bookshop.

—HAROLD KELMAN, M.D.
President

The Auxiliary Council to the Association

ACAAP has, in the past year, moved in the direction of greater autonomy while strengthening its ties to the parent organization, the Association. Within ACAAP a reorganization focused on definition of committee functions and the fixing and delegating of responsibilities, so necessary in an expanding group, was accomplished. To effect a clearer separation from the Association, one half the time of one secretary was allocated to ACAAP and to be directly under its supervision. This is a first step toward a full-time professional executive secretary who will co-ordinate and expand ACAAP's activities. To effect a closer liaison with the Candidates Association of the Institute, the ACAAP committee of that group, chaired for

two years by Dr. Isidore Portnoy, was enlarged to include Dr. Norman Kelman, Dr. Hugh Mullan, and Dr. Sidney Rose.

In its expanded quarters ACAAP offered six seminars, the average attendance was more than 50, and one had to close registration at 90. The topics were:

"Child-Parent Relations." Dr. Norman Kelman.

"Seminar for Clergymen." Dr. Paul Lussheimer.

"Personnel Problems." Dr. Sara Breitbart.

"Dr. Horney's Theory of Neurosis." Dr. Isidore Portnoy.

"Problems in Marriage." Dr. Bella S. Van Bark.

"Sex in Neuroses." Dr. Frederick A. Weiss.

Next year there will be five seminars. In keeping with policy, some seminars will be repeated and new ones added. Next year, a seminar on "Literary Figures in the Light of Modern Psychoanalysis" will be the innovation.

The paid lectures given at the Henry Hudson Hotel on the first Tuesday of each month were continued. The average attendance dropped to 250, due in the main to changing economic conditions. This year instead of a symposium, Dr. Horney gave one of the lectures entitled "Aims of Psychoanalytic Therapy" on February 2, 1949. The others were:

"Fostering Healthy Sex Attitudes in Children" (Dr. Norman Kelman, October 5, 1948); "Impotence in Men" (Dr. Abe Pinsky, November 9, 1948); "Human Nature Can Change" (Dr. Bella S. Van Bark, December 7, 1948); "New Trends in Psychoanalysis" (Dr. Frederick A. Weiss, January 11, 1949); "Living in an Ivory Tower —Isolation and Loneliness" (Dr. Antonia Wenkart, March 1, 1949); "The Fear of Appearing Ridiculous" (Dr. Morris Isenberg, April 5, 1949); "Brief Psychotherapy" (Dr. Sidney Rose, May 3, 1949).

Another innovation in the past year was the substituting for the President's monthly letter by the ACAAP *Record*. It has an attractive new format, contains a regular calendar of events, write-ups of special events, editorials, and book reviews. It is issued ten times a year and gives a much broader and more interesting picture of ACAAP activities—particularly to those members not close to New York City who cannot participate directly.

The other regular functions of ACAAP have been continued with even greater effectiveness: the orientation meetings for new members; the monthly Sunday discussion groups conducted for members, and participated in by three analysts on each occasion; the distribution of lecture summaries which now number 39; the maintenance of the lecture bureau through which over 50 different lay groups were addressed by analysts of the Institute.

—Harold Kelman, M.D.
Chairman, Liaison Committee
—Isidore Portnoy, M.D. *(Chairman)*
—Norman Kelman, M.D.
—Hugh Mullan, M.D.
—Sidney Rose, M.D.
Candidates Committee

The American Institute for Psychoanalysis

In the past year the Board of Trustees of the Institute *pro tem* concentrated mainly on the drafting of a constitution. This constitution was ratified on June 15, 1949, the Board of Trustees *pro tem* was dissolved, and the first meeting of members of the Institute was held. At this meeting members of the first Board of Trustees of the Institute were elected to serve according to provisions of the constitution, and chairmen and members of the Membership and Grievance Committees were elected. After this meeting the Board of Trustees met and elected officers of the Institute.

With the growth in the enrollment of candidates and the progress of candidates now well advanced in the course in training, we have been able to enlist many well-qualified trainees to assist in the courses. This practice offers the opportunity for candidates to broaden their experience; it tends to break down the line between student and teacher; and it makes for mutuality in educational development between faculty and candidates, senior candidates and juniors, and those who have been newly admitted. There has been a marked increase in the number of lectures given by candidates to

the public. This experience consolidates the candidates' understanding of psychoanalytic concepts and their application to everyday life. In the same way, the practice of writing term papers and summaries for ACAAP's bulletin publications is an educational adjuvant of considerable value.

A detailed critical review was made of each course given during the year as a guide to improvements when courses are repeated. The evaluations of courses by candidates have been studied with a view to selecting what is valuable in their suggestions. Recommendations are conveyed to the individual instructors for their consideration. Special attention was paid this year to a sharper delineation between "Continuous Case Seminars," "Clinical Conferences," and the course, "The Analytic Process." Of these three courses "Clinical Conferences" was discussed in greatest detail. The main issue in this course is that the student learns to size up the cases presented; special problems are discussed either in the same session, or—in the case of problems of special interest and complexity—in the following session.

Another course which received special study was "Sexual Problems in Neurosis." This course, given in six lecture-seminar sessions, was received with great interest. It was felt that it could be lengthened and elaborated and that the organization of the course could be improved by providing more time for discussion of clinical material.

The course, "Readings in Psychoanalysis, Part III, the Works of Karen Horney," given for the first time last year, proved very valuable in providing groundwork for the study of Horney's theory of neurosis. It will therefore not be necessary to include so much detail in the course, "Theory of Neurosis," as heretofore. This course, as planned for next year, will take on the character of an advanced study of the theory in which essential issues will be presented and thoroughly discussed. It is expected that the student who is already prepared by a systematic reading of Horney's works will get a more comprehensive grasp of the theory as a whole, and that those who have not had such preparation will approach Horney's contributions with a better understanding of the main issues.

The lecture course, "The Search for Inner Unity," presented an extensive elaboration of the material of the course, "At War With Ourselves," given in the previous year. Considerably more work was done on problems relating to inner psychic conflicts between the pride system of the idealized image and the real self and the neurotic solutions of these conflicts which the individual strives for.

In the lecture course, "Interpretation of Dreams," certain aspects of the theory of dreams were expanded and an attempt was made to present some philosophical issues involved in the theory.

Horney's approach to psychological problems has implied from the beginning the necessity for a philosophical point of view. In class discussions, especially in "Interpretation of Dreams," and in interval meetings of the Association it has become more and more evident that we needed some authoritative guidance from a professional philosopher. We have fortunately enlisted the interest and services of James G. Clapp, Ph.D., assistant professor of philosophy at Hunter College, who will conduct a lecture course entitled "Philosophy and Psychoanalysis." We look forward to the course as an opportunity to come to a clear understanding of basic philosophical issues as applied to psychoanalysis.

—Muriel Ivimey, M.D.
Associate Dean

Candidates Association

The membership of the Candidates Association has grown from 45 to 50 in the past year. Nine new candidates who were admitted to the Institute became members of our Association, three became associate members of the Association and one member left the Institute. During the year, five Juniors became Seniors; the current breakdown is 23 Juniors and 27 Seniors.

The following account of our activities shows the role we have played in the affairs of the Institute, the Association, and ACAAP. During the past year, six candidates participated as guest lecturers in the course, "Readings in Psychoanalysis, Part II." "Readings in Psychoanalysis, Part III,'" was conducted in its entirety by a Senior candidate. One candi-

date assisted in the lecture course, "Psychiatry and Psychoanalysis." Three candidates assisted as lecturers in the course, "Neuroses and Psychoses." One candidate took part on the team of three instructors who gave the "Seminar on Personal Case Histories." In all, ten candidates assisted in the teaching program of the Institute.

In the monthly scientific meetings of the Association at the New York Academy of Medicine, one of the candidates read an original paper, three candidates presented formal discussions of Academy papers, and many contributions were made by candidates in open discussions at these meetings. One candidate presented one of the main papers at the Association Interval Meeting.

Activities with ACAAP have been carried out through our ACAAP Liaison Committee and our Speakers Committee. The former committee has been expanded to four members and with the representative of the Association has attended the monthly meetings of the ACAAP Executive Committee. Candidates have delivered five out of the eight of ACAAP's monthly lectures to the laity series at the Henry Hudson Hotel. Four out of the six ACAAP seminars for the laity were conducted by candidates. Seven lecture summaries and pamphlets published by ACAAP were written by candidates. Our Speakers Committee arranged for the candidate discussants at the monthly ACAAP meetings and filled numerous engagements requested by lay and professional groups, such as parent-teacher organizations, medical societies, churches, and study groups.

In addition to the above activities with the Institute, the Association, ACAAP and various lay groups, the following intra-group activities have been carried out. Our Library Committee has begun an expansion of our functioning library by cataloging books in the personal libraries of candidates which are available for loan circulation. The House Committee has arranged for our Annual Dinner, the housewarming party in our new quarters, and the monthly collation following our business meetings.

The Referral Committee has clarified and systematized the work of distributing applications for psychiatric and psychoanalytic treatment. The Committee on Hospitals has compiled valuable data on resources for patients needing in-patient care and has distributed this to candidates and members of the Association. We have also begun publication of a monthly announcement bulletin.

The work of the Course-Evaluation Committee has been more clearly defined and administered in collaboration with the Faculty Council. The system introduced this year entails the calling of evaluation meetings at the close of each course, moderated by two candidates who report in writing to the Evaluation Committee. The final report is submitted to the Faculty Council. There has been an increasingly responsible attitude evident this year in evaluating courses, arising out of the more intimate conduct of the discussions and the response of the faculty to the constructive suggestions.

The general program at our monthly meetings has been devoted to the general topics relating to our responsibility as physicians, candidates of the Institute, members of the psychiatric profession and the community at large. Accordingly discussions under the following headings were scheduled: (1) Mutual Relations between the Candidates Association, the Institute, the Association, and ACAAP; (2) Responsibility as Physicians to the Patient and the Community; (3) The American Psychiatric Association—in recognition of the desirability to maintain contact with the psychiatric profession at large and to avoid any tendency toward sectarianism; (4) Discussion of various organizations of psychiatrists, psychotherapists, and psychoanalysts in which membership is open to us and whose meetings offer opportunities for exchange of opinion and the expression of our point of view.

This year has seen a considerable expansion of our work with other groups, within the Association, and with the laity, and a definite intensifying of our intra-organizational functioning. This has been a consequence of the maturing of our organization and the co-operative spirit of committees and the membership at large. Real self-interest and group responsibility has been evident in the extent of our efforts and the satisfying successes achieved.

—NORMAN KELMAN, M.D.
President

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